**Section 500.APPENDIX E Adoption Records**

**Section 500.ILLUSTRATION H Information Exchange Authorization Form**



**Illinois Department of Public Health**

**STATE OF ILLINOIS ADOPTION REGISTRY**

**INFORMATION EXCHANGE AUTHORIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, state that I am the person who completed the Registration Identification; that I am the age of \_\_\_\_\_ years; that I hereby authorize the Department of Public Health to give the (circle as applicable) (birth mother) (birth father) (birth sibling) (adopted/surrendered person) (adoptive mother) (adoptive father) (legal guardian(s)) the following:

(please check the information authorized for exchange)

1. Only my name and last known address.

2. A copy of my Illinois Adoption Registry application as specified in the application.

3. A copy of the original birth certificate of the adopted person.

4. A copy of the completed medical questionnaire.

I am fully aware that I can only be supplied with any information about each circled person if that person has duly executed an Information Exchange Authorization for the information which authorization has not been revoked; that I can be contacted by writing to

(insert your own name, complete mailing address and telephone number

or this same information for another person to contact)

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | | TELEPHONE NUMBER  ( ) | |
| STREET ADDRESS | | | |
| CITY | STATE | | ZIP CODE |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Dated | |  | | | , |  |
| (insert date) | | | | | | | |
|  | |  |  | | | |
| WITNESS | |  | SIGNATURE | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | |  | If adoption agency representative, please state title | | | | | | | | | |
|  | | | |  |  |  | | | | | | | |  |
| STATE OF |  | | |  | Name of agency | | | | |  | | | |  |
|  | | | |  | City | |  | | | | | | |  |
| COUNTY OF | |  | |  | State | | |  | | | Zip Code | |  |  |
|  | | |  |  |  | | | |  | | |  |  |  |

I, a Notary Public, in and for the said county, in the state aforesaid, do hereby certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ personally known to me to be the same person whose name is subscribed to the foregoing Information Exchange Authorization, appeared before me in person and acknowledged that he/she signed such authorization as his/her free and voluntary act and that the statements in such authorization are true.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Given under my hand and notarial seal on |  | | , | |  |
|  | | (insert date) | |

|  |
| --- |
|  |
| SIGNATURE OF NOTARY |

|  |  |
| --- | --- |
| Illinois Department of Public Health, Division of Vital Records, 605 W. Jefferson St., Springfield, IL 62702-5097 | |
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