**Section 500.APPENDIX E Adoption Records**

**Section 500.ILLUSTRATION I Denial of Information Exchange Form**

**Illinois Department of Public Health**

**STATE OF ILLINOIS ADOPTION REGISTRY**

**DENIAL OF INFORMATION EXCHANGE**



I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, state that I am the person who completed the Registration Identification; that I am the age of \_\_\_\_\_ years; that I hereby instruct the Department of Public Health ***not*** to give any information about me to the (circle as applicable) (birth mother) (birth father) (birth sibling) (adopted/surrendered person) (adoptive mother) (adoptive father) (legal guardian(s)); that I do not wish to be contacted.

(Insert your own name, complete mailing address and telephone number or this same information for another person to contact. This information is for administrative purposes only and will be used to provide written confirmation that this denial has been filed.)

|  |  |  |  |
| --- | --- | --- | --- |
| 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 Denial of Information Exchange, 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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