H105.702

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

WITHDRAWAL OF BIOLOGICAL PARENT CONSENT FORM

A biological parent completing this form revokes the authority of the Department of Health to release identifiable information to an adoptee, adoptive parents, or legal guardian. File form with the Division of Vital Records, P.O. Box 1528, New Castle, PA 16103. The Division of Vital Records will notify the biological parent in writing upon receipt of this form.

CHILD'S PERSONAL DATA

1. NAME (First, Middle, Last)	2. SEX	3. DATE OF BIRTH (Month, Day, Year)
4a. HOSPITAL NAME (If no hospital, give street & no.)	4b. CITY, BORO, OR TOWNSHIP OF BIRTH	4c. COUNTY OF BIRTH
5. MOTHER'S MAIDEN NAME (First, Middle, Last)		
6. IF KNOWN, LIST COURT, DOCKET NUMBER, COUNTY, STATE, AND DATE OF ADOPTION		

AFFIDAVIT OF BIOLOGICAL PARENT

Being duly sworn or by solemn affirmation, I state that I am the individual who completed and filed the Biological Parent Registration Identification Form for release of identifiable information to the above-referenced child. I hereby instruct the Department of Health not to release any information, and they may destroy the identifiable information form that I previously submitted.

Signature of Biological Parent _____

Current Name of Biological Parent (Please Print) _____

Complete Address (Please Print) _____

_____

SEAL

Sworn (or affirmed) before me and subscribed in my presence this _____ day of _____, 20 ____, by the person whose signature appears above and whose identity is either personally known to me or satisfactorily proven to me.

_____
SIGNATURE OF OFFICIAL ADMINISTERING OATH

Please use stamp or print name, municipality, county, and commission expiration date below.

FOR DEPARTMENT OF HEALTH USE ONLY.