ADOPTION MATCHING PROGRAM:
BIRTH PARENT CONTACT PREFERENCE

State Form 56535 (6-18)
INDIANA STATE DEPARTMENT OF HEALTH
IC 31-19-25-4.6

Mail to:
Indiana State Department of Health
Adoption Matching Program
2 North Meridian Street
Indianapolis, IN 46204

INSTRUCTIONS:

1. *This form is used by the birth parent, or parents, to restrict release of their identifying information.*
2. ***This form must be signed and dated in order to be valid.***
3. *Send this form(s) along with a copy of your valid government, state, or military identification to Indiana State Department of Health at the above address.*

Name	
Address *(number and street, city, state, and ZIP Code)* ***ADRESS MUST MATCH THE IDENTIFICATION PROVIDED.***	
Child's Birth Name	
Child's Date of Birth *(month, day, year)*	Child's Sex
Child's Place of Birth *(city, state, county)*	

Please Select Only One Box:

☐ **1.** I welcome my adopted child to contact me directly, and I authorize the release of my identifying information.

☐ **2.** I prefer to be contacted by my adopted child through an intermediary and I do not authorize the release of my identifying information directly to my adopted child.

If selecting option 2, please list a designated third party to act as the Intermediary.

_____
Name of the Intermediary

Or

☐ **3.** I do not want to be contacted by my adopted child in any way.

☐ **4.** I do not want to be contacted by my adopted child in any way, but I welcome the State Registrar to contact me to update my medical information.

_____ ____/____/____
Signature *Month Day Year*

****An adoptee who does not know which court entered the adoption decree regarding the adoptee may seek assistance from the state registrar.****
****This form will be replaced if a new Contact Preference Form is filed.****
****A photo copy of a Government, State, or Military valid identification must accompany this form.****

FOR OFFICE USE ONLY		
Date received *(month, day, year)*	Volume Number	Adoption Number
Certificate Number		Clerk's Initials