



**ADOPTEE'S REQUEST TO SEARCH FOR
AFFIDAVIT OF DISCLOSURE/NON-DISCLOSURE**

This application must be notarized.

I am at least 19 years of age and request a non-certified copy of my original birth record. I have included the \$13 fee. I understand that my birth parent must give permission to release the original birth information to me. To determine if permission has been given, I request a search for an Affidavit of Disclosure or Non-Disclosure.

ADOPTED FIRST NAME		ADOPTED MIDDLE NAME		ADOPTED LAST NAME
BIRTH MONTH	BIRTH DAY	BIRTH YEAR	SEX	CITY and COUNTY OF BIRTH
ADOPTED MOTHER'S FIRST NAME		ADOPTED MOTHER'S MIDDLE NAME		ADOPTED MOTHER'S MAIDEN NAME
ADOPTED FATHER'S FIRST NAME		ADOPTED FATHER'S MIDDLE NAME		ADOPTED FATHER'S LAST NAME

Signed or attested before me on:

_____ Date

_____ Signature of Adoptee

_____ Notary Public

_____ Name of Adoptee - Please print or type

_____ My commission expires:

_____ Street Address

_____ City, State, Zip

_____ Telephone Number

Please complete and return request and \$13 fee to:

Office of the State Registrar
Minnesota Department of Health
P.O. Box 64882
St. Paul, Minnesota 55164-0882