

MAIL TO:



Minnesota Department of Health
777 Cassette Street, Southeast
P.O. Box 5500
St. Paul, Minnesota 55155-0500
612-495-0100

SEARCH FOR AFFIDAVIT OF DISCLOSURE

I would like to have a check made to see if my birth parents have filed an Affidavit of Disclosure with your Department.

Full Adoptive Name _____

Birth Date: _____

City of Birth: _____

Adoptive Father's Name: _____

Adoptive Mother's Name: _____

Your Signature and Current Address:

Subscribed and Sworn to before me this _____ day of _____

(Notary Public) _____, Ct.
My Commission expires _____

Enclosed is my \$14.00 check or money order made payable to the "Treasurer, State of Minnesota".