



**ADOPTION MATCHING PROGRAM:
BIRTH PARENT CONTACT PREFERENCE**

State Form 56535 (R / 1-24)
INDIANA DEPARTMENT OF HEALTH
IC 31-19-25-4.6

INDIANA DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS B-4
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 Department of Health at the above address.

Name	
Address (number and street, city, state, and ZIP Code) ADDRESS 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

- 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