Reset Form

ADOPTION MATCHING PROGRAM: BIRTH PARENT NONRELEASE

State Form 46392 (R4 / 11-24)
INDIANA DEPARTMENT OF HEALTH
IC 31-19-25

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, Adoption Matching Program, 2 North Meridian Street, Indianapolis, IN 46204.*

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)*	

Select One:

1) This Nonrelease Form is to remain in effect for _____ years*.
If this form is to remain in effect during your lifetime, indicate 99 years.*

or

2) This Nonrelease Form shall expire on _____ /_____ /_____.
Month Day Year

or

3) If this form is to remain in effect after your lifetime, meaning your information and should never be released, please write your on initials this line. _____

If one of the above is not selected, this form will expire upon your death.

I wish to receive notice (90 days) prior to expiration: ☐ Yes ☐ No
If NO is checked, identifying information will be released to the adult adoptee upon request after the expiration date.

- -

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

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