SEARCH / DISCLOSURE NOTICE OF RIGHTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES - ADOPTIONS
SFN 942 (1-2023)

Clear Fields

I certify that a personal and confidential contact was made with me by a child-placing agency and that I received the following information:

(Read Carefully)

- ☐ The identifying information the agency has in regard to me;
- ☐ The nonidentifying information the agency has in regard to me;
- ☐ The date of the disclosure request of the adopted adult / birth parent / birth sibling;
- ☐ The right I have as the adopted adult / birth parent / sibling to refuse to authorize disclosure of identifying information regarding me;
- ☐ The right I have as the adopted adult / birth parent / sibling to authorize disclosure of identifying information information regarding me;
- ☐ The effect of my failure to respond to a request for disclosure. The child placing agency will treat my failure to respond as a refusal to authorize disclosure of identifying information, except that is does not preclude disclosure after my death.

Print Name Adopted Adult / Birth Parent / Sibling	Date of Birth
Signature of Adopted Adult / Birth Parent / Sibling	Date

FOR DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CHILD PLACING AGENCY USE
Complete upon submission to Department of Health and Human Services

Name of Adult Adoptee (including maiden name)

DISTRIBUTION: Original to the adopted adult, birth parent, sibling
Copies to child-placing agency and Department of Health and Human Services