# MUTUAL CONSENT VOLUNTARY ADOPTION REGISTRY

### COMPLETE APPROPRIATE SECTIONS OF THIS AFFIDAVIT AND RETURN WITH THE

то:	Arkansas Department of Human Services Division of Children and Family Services	
	ADOPTION REGISTRY	
	P.O. Box 1437, Slot S565	
	Little Rock, AR 72203-1437	

**REGISTRY NUMBER** OFFICIAL USE ONLY

For this registration, please indicate if you are the:

- Adoptee: (must be 18 years old to register to receive non-identifying information; must be 21 years old to receive identifying information) Complete sections A., B., D\* and E.
- Adoptive parent: (can receive non-identifying information only) Complete sections A., B. through question 5., and E.
- Relative(s) of the adoptee within the 2<sup>nd</sup> degree: (biological grandparent, aunt, uncle, cousin or sibling can receive identifying information only; complete all sections)
- **Birth parent of adoptee:** (complete sections A, C, D\* and E)

Specify relationship to adoptee

**REQUIRED FEE** 

**NOTE:** Persons registering to receive non-identifying information only, do not complete. This registration will be accepted only if the adoptee was or may have been placed for adoption by the State of Arkansas. Registration must be renewed every ten (10) years. No identifying information will be released until the adoptee is at least 21 years old. Registration may be withdrawn (in writing) at any time.

#### 1. Please indicate if this registration is for: Α. (both may be checked) □ Non-identifying information (health, genetic and

- Social history of adoptee) (\$5.00)
- □ Identifying information (\$20.00)

# 2. Please indicate whom you wish to be identified to:

- □ Adoptee
- □ Sibling(s) and/or other relative(s) within the 2<sup>nd</sup> degree. Birth parent(s) (Specify \_

- 3. FEE: Money order or cashiers check only. NO CASH OR PERSONAL CHECKS.
- 4. Registration is voluntary.

The Registry will not contact persons eligible to register in order to facilitate registration.

# 5. Change of address or name.

Registrants are responsible for notifying the Agency of any change of address or name. The agency has no duty to search for registrants who haven't notified the agency.

#### В. 1. Name and address of adoptee

	Last	First	Middle	Maiden
	Birth name	Other names k	nown by	
	Mailing address		Zip code	() Phone number
2	Date of birth of adoptee		F	
2.		Month / Day / Year	Race	e / Sex
3.	Place of birth of adopte	e (if known)		
	Hospital (if not hospi	tal, give street address)		
	City, town or village	County	State	e Zip code
4.	Indicate the name of the	e county and court of adoption (i	f known)	
	A		-	
	Name of county	Address		Zip code
	В			
	Name of court	Date of	f adoptive placement –	Month / Day / Year

#### 5. Name and address of adoptive mother and father (include name even if deceased).

Mother _				
_	Last	First	Middle	Maiden
Father				
	Last	Fi	rst	Middle

Mailing address

# 6. Siblings and/or 2<sup>nd</sup> degree relatives with whom you would like to be in contact.

Name and Relationship	Date of Birth	Last Known Address (include zip code)
1.		
2.		
3.		
4.		
5.		

# 7. Provide any other information you feel will be helpful in processing this application (use page 4 if additional space is necessary)

#### C. 1. Name and address of birth mother

Last	First	Middle	Maiden
Mailing address		Zip code	() Phone

## 2. Name and address of birth father

Last	First	Middle
		( )
Mailing address	Zip code	Phone

## 3. Name(s) given to child(ren) at birth with whom you would like to be in contact.

Name	Date of Birth	Birthplace Hospital/City/State	Date Released For Adoption
1.			
2.			
3.			
4.			
5.			

Zip code

4.	Provide any other information you feel would be helpful in processing this application.	(Use page 4 if
	necessary)	

<b>COUNSELING STATEMENT</b> (To be completed by identifying information only)	counselor for persons who are regis	tering to receive
I hereby confirm that		
ofAd	ddress	
completed a	one hour counseling session on	
Date of Birth		Date
required for registration with the Mutual Consent Vo	oluntary Adoption Registry of the Sta	te of Arkansas.
Signature of Counselor	Title	Date
Agency name	Agency address	
Phone Number	License Number	Effective Da
Phone Number IDENTIFICATION AND NOTARIZATION OF AFFI COMPLETE SECTION E.)		
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# **Space for Additional Comments**