Biological Father's Social & Medical History

Instructions for Completion:
*Please print clearly using dark ink.
*Complete all items. If you do not know the answer, please indicate "unknown," or if it does not apply, please indicate "n/a."

IDENTIFYING INFORMATION

Your Full Name (first, middle, last):_____

Current Address (no P.O. boxes): _____

Home #:_____ Cell #:_____ Work #:_____

Email Address: _____

Social Security #: _____ Date & Place of Birth: _____

Driver's License/ID Card #:_____ State:_____ Expiration: _____
Please provide a copy of your Driver's License or ID Card.

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you in the Military? ☐ Yes ☐ No If yes, details: _____

Emergency Contact Name/Relationship: _____ Phone #: _____

PHYSICAL DESCRIPTION

Race (check all that apply): ☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American
☐ Pacific Islander ☐ Native American ☐ Other: _____

Ethnicity/Nationality (ex. French, Irish, etc.): _____ U.S. Citizen? ☐ Yes ☐ No

Height: _____ Weight: _____ Body Structure: _____

Eye Color: _____ Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

Complexion: ☐ Fair ☐ Olive ☐ Tan ☐ Dark ☐ Other: _____

Natural Hair Color: ☐ Blonde ☐ Brown ☐ Red ☐ Other: _____

Hair Texture: ☐ Straight ☐ Curly ☐ Wavy ☐ Other: _____

NATIVE AMERICAN INDIAN TRIBAL MEMBERSHIP

Do you have any Native American heritage? ☐ Yes ☐ No

Do you qualify to be a member or are you currently a member of any Native American tribe? ☐ Yes ☐ No
If yes, please indicate the name of the tribe, its location and your registration or identification number:
_____

Do you currently or have you ever lived on an American Indian reservation? ☐ Yes ☐ No

Are any of your relatives members or qualify to be members of any Native American Indian tribes? ☐ Yes ☐ No

If you checked yes to any of the questions in this section, please list the name (including maiden/former names) of each relative with any Indian affiliation, date of birth, current address, registration number and the name and location of their tribe. Also state if the relative has ever lived on an Indian reservation. _____
_____
_____

PREGNANCY & ADOPTION INFORMATION

Birth Mother's Name: _____ Due Date: _____

How and when did you meet the birth mother? _____

Please describe the nature and length of your relationship with the birth mother. If you are no longer together, please state when the relationship ended and why. _____

_____

_____

Date of your last physical contact with the birth mother: _____

Date of your last phone call, text or email contact with the birth mother: _____

When and how did you first find out about the pregnancy? _____

_____

When and where (city, state) did conception occur? _____

Have you ever worked with another adoption agency or lawyer? ☐ Yes ☐ No

If yes, who and when? _____

Who first thought of the idea of adoption? _____

With whom do you currently live? _____

Do they know about the pregnancy? ☐ Yes ☐ No

Do they know about the adoption plan? ☐ Yes ☐ No

Are they supportive of the adoption plan? ☐ Yes ☐ No

Describe your feelings and reasons why you are placing your child for adoption: _____

_____

_____

_____

_____

On a scale of 1 to 10, with 1 representing a mild curiosity about the adoption process and 10 representing an absolute resolve to place your baby for adoption, where would you consider yourself at this time? _____

Are you involved in any litigation with the birth mother? ☐ Yes ☐ No

If yes, please list the type of action, where it was filed and the names of the lawyers involved:_____

_____

Is there any litigation pending regarding this child (custody, paternity, etc.)? ☐ Yes ☐ No

If yes, please list the type of action, where it was filed and the names of the lawyers involved:_____

_____

Have you ever filed a petition to be declared the father of the child in any Court or otherwise been identified to be the father of the child? ☐ Yes ☐ No If yes, what Court and when? _____

Did you live with the birth mother before or during the pregnancy? ☐ Yes ☐ No

If yes, list all dates and timeframes that you lived together: _____

PREGNANCY & ADOPTION INFORMATION (continued)

Have you given or offered any financial support to the birth mother during this pregnancy? ☐ Yes ☐ No

If yes, explain in detail:_____

Have you given or offered any emotional support to the birth mother during this pregnancy? ☐ Yes ☐ No

If yes, explain in detail:_____

Have you given or offered any physical support to the birth mother during this pregnancy (i.e. given her rides to the doctor's office, attended doctor's appointments, taken her to the grocery store)? ☐ Yes ☐ No

If yes, explain in detail:_____

CONTACT WITH ADOPTIVE FAMILY

Do you want to select the adoptive family? ☐ Yes ☐ No ☐ Undecided

Do you want picture/letter updates from the adoptive family after the adoption? ☐ Yes ☐ No ☐ Undecided

If yes, how often and for how long? _____

Do you want to meet the adoptive family at the time of placement? ☐ Yes ☐ No ☐ Undecided

If it is possible, do you want to meet the adoptive family prior to the birth of the child? ☐ Yes ☐ No ☐ Undecided

Please initial your selections below:

Do you authorize us to disclose your name, address, phone # and email to the adoptive parents? Yes ___ No ___

Do you authorize us to disclose a picture of you to the adoptive parents? Yes ___ No ___

Please include any additional characteristics or preferences you would like to see in an adoptive family:

_____

_____

_____

_____

_____

EMPLOYMENT & EDUCATION HISTORY

Current Occupation/Job:_____

Name of Employer and Address: _____

Did you graduate High School? ☐ Yes ☐ No If no, what was the highest grade level completed? _____

Have you attended college or had any technical school training? ☐ Yes ☐ No

If yes, details: _____

What are your educational goals? _____

_____

Hobbies & Interests: _____

_____

_____

YOUR CHILDREN

How many children do you have? _____ Do they currently live with you? ☐ Yes ☐ No

If they do not live with you, please explain: _____

	1	2	3	4
Name				
Date of Birth				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Full/half sibling to the adoptee?	☐ Full ☐ Half	☐ Full ☐ Half	☐ Full ☐ Half	☐ Full ☐ Half
If deceased, age & cause.				
Height & Weight				
Natural Hair Color				
Eye Color				
Complexion				

Check this box ☐, if additional children are listed on the back of this page.

YOUR FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No	Your Biological Mother	Your Biological Father
Name		
Date of Birth		
If deceased, age and cause.		
Race/Ethnicity		
Height & Weight		
Natural Hair Color & Texture		
Eye Color		
Complexion		
Education Level Completed		
Current Occupation		
Hobbies/Interests		
Are they aware of your pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No
Are they aware of your adoption?	☐ Yes ☐ No	☐ Yes ☐ No
Are they supportive?	☐ Yes ☐ No	☐ Yes ☐ No

YOUR BIOLOGICAL SISTERS & BROTHERS

Are you a (check only if applicable): ☐ Fraternal Twin ☐ Identical Twin ☐ Triplet ☐ Other Multiple Birth

Total # of siblings: _____	1	2	3	4
Name				
Gender	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
Full or Half Sibling to you?	☐ Full ☐ Half	☐ Full ☐ Half	☐ Full ☐ Half	☐ Full ☐ Half
Date of Birth				
If deceased, age and cause.				
Race/Ethnicity				
Height & Weight				
Natural Hair Color & Texture				
Eye Color				
Complexion				
Education Level Completed				
Current Occupation				
Hobbies/Interests				
Are they aware of your pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are they aware of your adoption?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are they supportive?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

List information on additional siblings below:

YOUR FAMILY MEDICAL HISTORY

Please indicate if you or your family has any of the following medical history by checking the appropriate boxes below. For any condition checked "Yes," please provide specific details about the cause, treatment and age of onset, as applicable. If any condition resulted in a relative's death, please note the age at which they died.

	Self	Relative	If yes, please provide the cause, treatment and age of onset, as applicable.
Congenital Heart Defect	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Fetal Drug Exposure	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Fetal Alcohol Syndrome	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Turner's Syndrome	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Down's Syndrome	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hydrocephalus	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Spina Bifida	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Cerebral Palsy	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Clubbed Foot	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Cleft Palate	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Cleft Lip/Harelip	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Scoliosis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Anemia	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hemophilia	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Leukemia	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Sickle Cell Trait	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Sickle Cell Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hepatitis A, B, or C (specify)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Lou Gehrig's Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Huntington's Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Multiple Sclerosis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Neurofibromatosis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Parkinson's Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Tay-Sachs Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Muscular Dystrophy	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Cystic Fibrosis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Coronary Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	

YOUR FAMILY MEDICAL HISTORY (continued)

	Self	Relative	If yes, please provide the cause, treatment and age of onset, as applicable.
Heart Murmur	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Anorexia/Bulimia	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Breast Cancer	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Cervical Cancer	N/A	☐ Yes ☐ No If yes, who? _____	
Ovarian Cancer	N/A	☐ Yes ☐ No If yes, who? _____	
Uterine Cancer	N/A	☐ Yes ☐ No If yes, who? _____	
Prostate Cancer	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Lung Cancer	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Stomach Cancer	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Liver Cancer	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Colon Cancer	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Melanoma/Skin Cancer	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hodgkin's Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Other Cancer (specify type)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Benign Tumor(s)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Periodontal Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Gingivitis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Overbite/Underbite	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Dentures	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Mental Retardation	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Attention Deficit Disorder	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hyperactivity	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hearing Impaired	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Speech Impaired	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Learning Disability	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Emotionally Disturbed	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Autism	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Alzheimer's Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Depression	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Suicidal	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Psychosis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Schizophrenia	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	

YOUR FAMILY MEDICAL HISTORY (continued)

	Self	Relative	If yes, please provide the cause, treatment and age of onset, as applicable.
Manic Depressive/Bipolar	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Multiple Personality Disorder	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Slipped Disk(s)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Pinched Nerve(s)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Rheumatoid Arthritis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Juvenile Arthritis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Osteoporosis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Paralysis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Dwarfism	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Psoriasis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Eczema	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Blindness	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Near Sighted	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Far Sighted	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Color Blindness	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Crossed Eyes	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Epilepsy/Seizures	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Tourette's Syndrome	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Gonorrhea	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Chlamydia	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Syphilis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Herpes	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
HPV	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Pelvic Inflammatory Disease	N/A	☐ Yes ☐ No If yes, who? _____	
HIV/AIDS	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Thyroid Disorder/Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Diabetes (specify type)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Crohn's Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Lyme Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	

YOUR FAMILY MEDICAL HISTORY (continued)

	Self	Relative	If yes, please provide the cause, treatment and age of onset, as applicable.
Gall Stones	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Gall Bladder Problems	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Lupus	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Liver Disease	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Kidney Stones	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Congestive Heart Failure	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Stroke	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Heart Attack	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hypoglycemia	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Obesity	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Malnutrition	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Ulcers	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Colitis	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Endometriosis	N/A	☐ Yes ☐ No If yes, who? _____	
Multiple Births (twins/triplets)	N/A	☐ Yes ☐ No If yes, who? _____	
Premature Births	N/A	☐ Yes ☐ No If yes, who? _____	
SIDS	N/A	☐ Yes ☐ No If yes, who? _____	
Infertility	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Menstrual Problems	N/A	☐ Yes ☐ No If yes, who? _____	
Asthma	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Food Allergies	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Drug Allergies	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Hay Fever/Seasonal Allergies	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Other (specify)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Other (specify)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Other (specify)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Other (specify)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	
Other (specify)	☐ Yes ☐ No	☐ Yes ☐ No If yes, who? _____	

CONFIDENTIAL DRUG & ALCOHOL USAGE

Please be very specific as to any drugs or alcohol that you have used or are currently using. This information will be shared with the adoptive family and the child's pediatrician.

	Currently?	In the Past?	What Type & How Often?
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	
Cigarettes/Nicotine	☐ Yes ☐ No	☐ Yes ☐ No	
Caffeine	☐ Yes ☐ No	☐ Yes ☐ No	
Diet Pills	☐ Yes ☐ No	☐ Yes ☐ No	
Marijuana	☐ Yes ☐ No	☐ Yes ☐ No	
Cocaine/Crack	☐ Yes ☐ No	☐ Yes ☐ No	
Anti-Depressants	☐ Yes ☐ No	☐ Yes ☐ No	
Hallucinogens	☐ Yes ☐ No	☐ Yes ☐ No	
Inhalants	☐ Yes ☐ No	☐ Yes ☐ No	
Ecstasy	☐ Yes ☐ No	☐ Yes ☐ No	
Heroin	☐ Yes ☐ No	☐ Yes ☐ No	
Tranquilizers	☐ Yes ☐ No	☐ Yes ☐ No	
Methadone	☐ Yes ☐ No	☐ Yes ☐ No	
Suboxone/Subutex	☐ Yes ☐ No	☐ Yes ☐ No	
Methamphetamines	☐ Yes ☐ No	☐ Yes ☐ No	
Xanax	☐ Yes ☐ No	☐ Yes ☐ No	
Valium	☐ Yes ☐ No	☐ Yes ☐ No	
Ritalin/Adderall	☐ Yes ☐ No	☐ Yes ☐ No	
Hydrocodone/Vicodin	☐ Yes ☐ No	☐ Yes ☐ No	
Oxycodone/Percoset	☐ Yes ☐ No	☐ Yes ☐ No	
Klonopin/Ativan	☐ Yes ☐ No	☐ Yes ☐ No	
Codeine/Morphine	☐ Yes ☐ No	☐ Yes ☐ No	
Other (be specific)	☐ Yes ☐ No	☐ Yes ☐ No	

Please list any other prescription drugs or medications that you are currently taking:

Name: _____ Prescribed For: _____

How Much & How Often? _____

Please list any other non-prescription/over-the-counter drugs or medications that you are currently taking:

Name: _____ Taken For: _____

How Much & How Often? _____

Please list any other pertinent medical information that was not covered in this form: _____

_____

_____

_____

_____

Please list any additional comments, concerns or questions you may have that we may be able to assist you with:

_____

_____

_____

_____

I represent that the information contained in the Biological Father's Social and Medical History is true and accurate. I acknowledge that the adoptive family and other parties will rely on this information in making a determination to proceed with the anticipated adoption and the court will rely on this information during the adoption related proceedings. I hereby waive any claim of privilege and agree that the information contained on this form and any information provided by myself, my counselors and my physicians may be given to the attorneys for adoptive parents, adoptive parents, agency for adoptive parents, attorneys for adoption agency, court in connection with adoption, Interstate Compact on the Placement of Children, other attorneys and adoption entities, and other state officials, including law enforcement authorities, through all communication medium.

I further understand that I am entering into a program that places children for adoption and any false statements may be viewed as perjury and in violation of penal laws of my state and may subject me to criminal and/or civil penalties under the law. I also understand that it is unlawful for a parent, with the intent to defraud, to accept benefits related to the same pregnancy from more than one adoption entity without disclosing that fact to each entity.

In my written and verbal communications in connection with my adoption plan, I have not provided any false or misleading information of any kind including information concerning myself, the birth mother or the background or medical history of my family.

I hereby authorize the Adoption Entity to make inquiry about the truthfulness of the statements made in this document and the circumstances of this placement with other medical, legal and adoption professionals through all communication medium.

Under penalties of perjury, I declare that I have read the foregoing and the facts stated in the document are true, and acknowledge that a copy of this document is as effective as an original for all purposes.

_____ _____

Biological Father's Signature Date