

**CHILDREN'S HOME SOCIETY OF CALIFORNIA  
POST ADOPTION PROGRAM**

1300 West Fourth Street, Los Angeles, CA 90017

**SERVICE REQUEST FORM**

**Current Legal Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Address (City, State & Zip):** \_\_\_\_\_

**You are the:** ( ) **Adult Adoptee** ( ) **Birth Parent** ( ) **Adoptive Parent** ( ) **Other (Specify):** \_\_\_\_\_

**Request is For:**

- ( ) Non-Identifying Background Report (including Medical) (Enclose \$100.00 Fee)
- ( ) Non-Identifying Medical Report Only (No Fee)
- ( ) *Consent for Contact Form*
- ( ) *Adoptions Information Act Statement Form* (for adoptions for which birth parents' legal rights were ended voluntarily or involuntarily on or after January 1, 1984).
- ( ) *Waiver of Rights to Confidentiality for Siblings Form*
- ( ) *Waiver of Rights to Confidentiality for Siblings – Under the Age of 18 Form*
- ( ) *Authorization for Release of Personal Items Form*
- ( ) *Request for Personal Items Form*
- ( ) Other (Please specify): \_\_\_\_\_

**If you are an Adoptee, Adoptive Parent, or related to an Adoptee (i.e., child/grandchild), please complete this section to the best of your ability:**

Full Name of Adoptee: \_\_\_\_\_

Adoptee's Date & Place of Birth: \_\_\_\_\_

Full Names of Adoptive Parents: \_\_\_\_\_

Year Adoption Finalized in Court: \_\_\_\_\_

City and/or County Adoption Finalized: \_\_\_\_\_

**If you are a Birth Parent, Sibling, or related to a Birth Parent, please complete this section to the best of your ability:**

Birth Parent(s) and Child's Name at Time of Relinquishment and Dates of Birth (DOB):

Birth Mother: \_\_\_\_\_ DOB: \_\_\_\_\_

Birth Father: \_\_\_\_\_ DOB: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_

CHS Office Where Relinquishment Was Signed: \_\_\_\_\_

City & County Where Relinquishment Was Signed: \_\_\_\_\_

Date Child Was Relinquished: \_\_\_\_\_

**Signature (Required):** \_\_\_\_\_ **Date:** \_\_\_\_\_