CHILDREN'S HOME SOCIETY OF CALIFORNIA
POST ADOPTION PROGRAM
1300 West Fourth Street, Los Angeles, CA 90017
(800) 564-9095

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 Arranging 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:** _____