Clear Form

Minnesota Department of **Human Services**

DHS-4841-ENG 1-13

Minnesota Health Care Programs

Authorization to Request Birth Records

Date: _____

Case number: _____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

_____

Authorization for Release of Birth Records

1. I authorize the _____ vital statistics office, during the effective dates of this release form (see #3 below), to give birth records for me and/or my family members to the agency named above.
   NAME OF STATE
2. I also authorize the agency named above to give information about my case to the _____ vital statistics office during the effective dates of this release form (see #3 below), to the extent necessary to get the information described in 1 above.
   NAME OF STATE

Enrollee/Applicant Information

1. This information will be used to decide if I can get Minnesota Health Care Program coverage. I know that this information will be shared with staff in the agencies named above who need it to do their jobs.
2. I know that my records are protected by law and generally can be given out only if I authorize their release.
3. I also understand that those who receive my records under this release may share it with others if permitted or required by law. Once the information is shared with others, it may no longer be protected by this authorization.
4. I know that this authorization is effective for one year after the date that I sign this form.
5. I know that I may cancel this authorization at any time by giving a written cancellation. Such cancellation will not apply to information shared before I sign this form and give it to the state/county agency.

Note to Vital Statistics Office: Applicant/enrollee can see certain information in their files. We must show them the information you provide pursuant to this authorization if the applicant/enrollee asks to see it.

A copy or fax of this form may be used in place of the original.

SIGNATURE OF APPLICANT/ENROLLEE OR AUTHORIZED REPRESENTATIVE	DATE

PRINT NAME AT BIRTH	PRINT CURRENT NAME

SIGNATURE OF SPOUSE (if needed)	DATE

Request for Birth Record

Case number: _____

To: Vital Statistics Office

Return this document to the agency and address on front page.

Request to Vital Statistics Office

☒ Please provide a certified copy of the birth record for the person named below

☐ Please verify the information below. Correct, add or delete information to accurately reflect what is shown in the official record.

Birth Information

NAME First	Middle	Last	DATE OF BIRTH	◯ Male ◯ Female

PLACE OF BIRTH

CITY	STATE	COUNTY	HOSPITAL

MOTHER'S FULL MAIDEN NAME First	Middle	Last

FATHER'S FULL NAME First	Middle	Last

Do not write below this line – Vital Statistics use only

SIGNATURE OF VERIFYING AGENT – *I verify that the above data is true and correct according to the records in this office.*

CERTIFICATE NO.	DATE FILED

VERIFIED BY	DATE

Return this document and all correspondence to the agency and address printed on front page.

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling local 651-431-2670, toll-free 800-657-3739, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.