PUBLIC HEALTH DIVISION
Center for Prevention and Health Promotion
Reproductive Health Program

800 NE Oregon Street
Portland, OR 97232
Voice: 971-673-0355
Fax: 971-673-0371

Authorization to Release Birth Certificate

I _____, authorize my birth state, _____, to release
(Print name) *(Birth state)*
a certified copy of my birth certificate to the Oregon Reproductive Health Program with the Oregon Health Authority, Public Health Division.

_____ _____
(Signature) *(Date)*

If required by the client's birth state, please include notary signature and seal:

_____
(Notary signature)

_____
(Notary seal)

****FOR CLINIC STAFF USE****

Staff name: _____
Project number: _____
Clinic number: _____
Client's RH Program number: _____

****FOR STATE STAFF USE****

TO STATE VITAL RECORDS AGENT: I am entitled to receive a copy of the requested certificate. Documentation of a U.S. place of birth from the client's official birth record is required for the determination and the protection of the client's personal right to eligibility for reproductive health services provided under the Oregon Health Authority's Oregon Reproductive Health Program. All client information will be kept strictly confidential as required by law. Please mail document to the address below:

State of Oregon Reproductive Health Program
Oregon Health Authority
800 NE Oregon St., Suite 370
Portland, OR 97232
Phone: 971-673-0355
Fax: 971-673-0371

Date: _____
Staff name: _____
Staff signature: _____