

Deaconess Pregnancy & Adoption Services, LLC

7101 NW Expressway, Suite 325 ♦ Oklahoma City, Oklahoma 73132 ♦ Phone: (405) 949-4200 ♦ Fax: (405) 720-8686
www.deaconessadoption.org

REQUEST FOR CONFIDENTIAL INTERMEDIARY SEARCH

Fee: \$200.00 per 1 search, \$150.00 per additional search

Although some parties may have a strong desire to obtain identifying information and pursue a relationship, others may not. This program is voluntary for all participants and Deaconess Pregnancy & Adoption Services (DPAS) fully recognizes the right to privacy and confidentiality of all people involved.

Your Name: _____

Address: _____

City/State/Zip: _____

Phone Number: Residence (____) _____

Cell or Business (____) _____

Email: _____

If known, please answer the following questions regarding the adoption.

Person you want to contact: _____ Your relationship to this person: _____

Birth Mother's name: _____ Alias: _____

Birth Father's name: _____ Alias: _____

Child's Name: _____ Child's Birth Date: _____

Adoptive Parent's names: _____

I hereby request that DPAS conduct a confidential search for the above listed person.

I understand there is no guarantee the person I am seeking will be located. I understand that upon location, the person being sought will be informed about the provisions of the Agency's Reunion Registry and the Confidential Intermediary Search Program and will be given forms and information to register. If the person I am searching for is contacted, and declines to give her/his consent, I understand no identifying information will be released to me, according to Chapter 75 of the Oklahoma Adoption Code, Section 45. _____
Initials

I understand that no pressure to participate will be placed on the person I am seeking. I understand that I will not be entitled to a refund of fees in the event that the search is unsuccessful, the person located declines further contact, or for any other reason once payment has been made to DPAS. _____
Initials

I hereby request that DPAS conduct a confidential search for the above-listed person. I understand if I want to search for more than one person, the additional fee of \$150.00 is required for each search. _____
Initials

I hereby release DPAS and its employees and agents from any liability or responsibility relating to or arising out of this search. _____
Initials

Signature

Date

STATE OF _____)

COUNTY OF _____)

Subscribed and sworn to before me on the _____ day of _____, 20____.

My Commission Expires:

Notary Public

Attach two of the following identity verifications:

- Birth Certificate
- Social Security Card
- Driver's License

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WAIVER OF CONFIDENTIALITY

Fee: \$150.00

This program recognizes that while some parties may have a strong desire to obtain identifying information, others may not. This program is voluntary for all participants and fully recognizes the right to privacy and confidentiality of all people involved. If the person you are searching for has not filed a waiver, this fee can be transferred toward the cost associated with a Confidential Intermediary Search.

I, _____, (adoptive, birthparent, relative), do hereby request and authorize Deaconess Pregnancy & Adoption Services, LLC to release confidential information in my records, including my present name and address to the following:

Birth parents Adoptive Son or Daughter Relatives

Your Name: _____

Address: _____

City/State/Zip: _____

Phone Number: Residence (____) _____

Business (____) _____

Email: _____

If known, please answer the following questions regarding the adoption.

Person you want to contact: _____

Your relationship to them: _____

Birth mother's name: _____ Alias: _____

Birth father's name: _____ Alias: _____

Child's Name: _____ Child's Birth Date: _____

Adoptive Parent's Names: _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. _____
Initials

I hereby release Deaconess Pregnancy and Adoption Services, LLC and its employees and agents from any liability or responsibility relating to or arising out of this program. _____
Initials

Signature

Date

STATE OF _____)

COUNTY OF _____)

Signed or attested before me on the _____ day of _____, 20____.

My Commission Expires:

Notary Public

Please attach two of the following verifications of identity:

- Birth Certificate
- Social Security Card
- Driver's License