

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)

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 #: _____
Clinic #: _____
Client's CCare #: _____

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 Contraceptive Care (CCare) Medicaid waiver 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	Date: _____
Oregon Health Authority	Staff Name: _____
800 NE Oregon St., Suite 370	Staff Signature: _____
Portland, OR 97232	
Phone: (971) 673-0355	
Fax: (971) 673-0371	