South Carolina Department of Social Services

ADOPTION REUNION REGISTER
BIOLOGICAL SIBLING

Name of Adopted Sibling: _____

Date of Birth: _____ Sex of Child: _____

Name of Birth Mother at Time of Birth: _____

I understand that:

- Completing and returning this affidavit enters my name on the Register.
- This affidavit will remain on file, unless I send a **written** request to have it removed.
- It is my responsibility to update this registration, **in writing**, if there is a change of name, address or telephone number.
- When a match occurs, the agency will contact me, using the latest information that I have provided, to schedule the required counseling.
- After the counseling is completed, the law requires a 30-day waiting period.
- At the end of the waiting period, I will receive notification of name, address and telephone number of the other party and I am at liberty to pursue the actual reunion in a mutually acceptable manner.

AFFIDAVIT

PERSONALLY APPEARS the undersigned party, who being duly sworn, deposes and says that as the biological sibling of the child named above, I am willing to have my identity, address and telephone number, shown below, revealed to this child, now an adult; that I freely and voluntarily release and hold harmless the State of South Carolina and its adoption agencies and all employees thereof from any liability which may accrue by reason of the release and disclosure of this information.

_____
Signature

_____
Printed Name

_____
Printed Street Address

_____
Printed City, State, Zip Code

_____
Home Telephone (With Area Code)

_____
Work Telephone (With Area Code)

SWORN TO AND SUBSCRIBED BEFORE ME THIS, THE

_____ DAY OF _____, 20 ___.

_____
Notary Public

STATE OF: _____

MY COMMISSION EXPIRES: _____