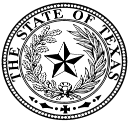

ACKNOWLEDGMENT OF PATERNITY
INQUIRY REQUEST FORM

Budget: ZZ712-153
Fee Received: ______
___ Positive Search
___ Negative Search
Date Mailed/ Fax: _______

The AOP Registry only includes Acknowledgments of Paternity filed from September 1, 1999 to the present.

Name of Child: ______________________________________ Date of Birth:_______

City or County of Birth: ______________________________

Mother's complete name: _____________________________ Date of Birth:________

Biological Father's name: _____________________________ Date of Birth:________

Name and address of Person making the Inquiry:

First	Middle	Last	
Address	City	State	Zip Code

( ) Daytime Telephone Number ( ) Fax number

Family Code §160.313 limits access to AOP's to the following individuals/agencies:

Relationship: ___ Mother ___ Father ___ Presumed Father ___Court Ordered for Attorney

Release: I authorize you to give the copy of the above-identified Acknowledgment of Paternity form to:

____

____ _____________
SIGNATURE OF REQUESTOR **DATE**

This inquiry request requires a search fee. A copy of a government issued identification is required. If paying by credit card the fee is $13.50. If paying by check or money order the fee is $10.00. Make check or money order payable to Texas Department of State Health Services (DSHS) -ZZ712. Mail completed form and fee to the address below. This inquiry may also be faxed to 512-458-7164 and paid with MasterCard, Visa, or Discover.

If faxed:

___ **M/C**
___ **VISA**
___ **DISCOVER**

ACCT # ________________________________ **EXP DATE** ____________

NAME OF CARDHOLDER ______________________________________

CARDHOLDER ADDRESS______________________________________

3 - DIGIT SECURITY CODE ______________**(Found on back of card).**

CARDHOLDER PHONE NUMBER_________________________________

Mail To: AOP Registry
Texas Department of State Health Services
P.O. BOX 12040
Austin, Texas 78711-8040

VS-134.1 Rev 01/2008