

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH 313 N. FIGUEROA ST. RM L-1, LOS ANGELES, CA 90012 (213) 288-7812



APPLICATION FOR CERTIFIED COPY OF BIRTH RECORD (We maintain records of births until the child's first birthday)

Pursuant to Health and Safety Code 103526, the following individuals are entitled to an AUTHORIZED Certified Copy of a birth record.

- ❖ The registrant or a parent or legal guardian of the registrant
- A party entitled to receive the record as a result of a court order, or an attorney or a licensed adoption agency seeking the birth record in order to comply with the requirements of Section 3140 or 7603 of the Family Code
- A member of a law enforcement agency or a representative of another governmental agency, as provided by law, who is conducting official business.
- A child, grandparent, grandchild, sibling, spouse or domestic partner of the registrant
- An attorney representing the registrant or the registrant's estate, or any person or agency empowered by statute or appointed by a court to act on behalf of the registrant or the registrant's estate.

Those who are not authorized may receive an INFORMATIONAL Certified Copy with the words "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY" imprinted across the face of the copy.

MAIL REQUESTS FOR AUTHORIZED COPIES MUST BE ACCOMPANIED BY A NOTARIZED CERTIFICATE OF IDENTITY

☐ I am requesting an AUTHORIZE I	D copy □	l am requesti	ng an INFORMATIC	DNAL copy
AGE LAST BIRTHDAY - EDAD CUMPLIDA	NUMBER OF COPIES NUMERO DE COPIAS			FOR DPH USE ONLY
	Month/Mes	Day/Dia	Year/Año	Receipt/Log #
Date of Birth - Fecha De Nacimiento				
NAME GIVEN AT BIRTH (first, middle , last) -NOMBRE DE NACIMIENTO (prime	er, segundo, appellido)]
CITY OF BIRTH - CIUDAD DE NACIMENTO				_ BNPNS#
NAME OF FATHER - NOMRE DEL PADRE				-
MAIDEN NAME OF MOTHER - NOMBRE DE SOLTERA DE LA MADRE				
RELATIONSHIP TO REGISTRANT (SEE ABOVE) – PARENTESCO CON LAS PERSOI	NA REGISTRADA (VEASE ARRIBA)]
I swear (o authorized person, as defined in California Hea to receive an AUTHORIZED certified copy of the Sworn this day of,	Ith and Safety Code S birth record identifi	Section 103525 ed on this appl	(c), and am eligible ication form.	Veterans-See reverse side of first copy Veteranos-Vean el dorso de la segunda copia
Signature				
DL/ID Phone Complete your name and mailing address below. NAME/NOMBRE	Number - Escriba abajo su n			_
STREET ADDRESS/NUMERO Y CALLE				
CITY / CIUDAD STATE / ESTADO ZIP / ZONA POSTAL				

SPECIAL NOTICE TO VETERANS

You may be eligible for a free certified copy if you are applying for a veteran's pension or certain other Veteran's Administration benefits. (Section 6107, Government Code State of California)

THIS DOES NOT APPLY TO SOCIAL SECURITY AND OTHER CIVILIAN BENEFITS, EVEN IF YOU ARE A VETERAN.

If you believe you qua	llify for a free certified	copy under these provision	ns, comple	te the following affida
	ee certified copy of the	record as shown on the refurnished to	everse side	and declare under
		in a claim for		
FEDERAL OR STATE AGENCY			BENEFIT	
DATE	SIGNATURE OF V	/ETERAN OR AUTHORIZED AGENT	RELA	TIONSHIP OF AGENT
	NUMBER-STREET			
	CITY	STATE	ZIP	

Note: The free copy issued on this affidavit will bear the following wording:

This certified copy has been issued free of charge on the declaration under penalty of perjury that it is to be used in a claim to the Federal Government or the State of California for veteran's benefits.



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Isw authorized person, as defined in Californ to receive an AUTHORIZED certified copy Sworn this day of	ia Health and of the birth r	Safety Code S ecord identifie	ection 103525(d on this applic	c), and am eligible ation form.	of first copy Veteranos-Vean el dorso de la segunda copia
Signature					
DL/IDP	hone Numb	er		-	
Complete your name and mailing address l	below. – <i>Escri</i>	ba abajo su no	mbre y direccio	on.	
NAME/NOMBRE					
STREET ADDRESS/NUMERO Y CALLE					
CITY / CIUDAD STATE/ESTADO ZIP/ZONA POSTA	NL				