

## ADULT PERSON BORN AS A RESULT OF A SURROGACY ARRANGEMENT

## DETAILS PROVIDED VOLUNTARILY FOR DISCLOSURE TO BIRTH PARENTS &/OR EGG/SPERM DONORS (Assisted Reproductive Technology Act 2007, section 41G)

PLEASE INDICATE REGISTRATION TYPE:			NEW (	or UPDATIN	☐ UPDATING	
INFORMATION TO BE ENTERED ON THE CENTRAL REGISTER (any or all sections may be answered)						
All information on this Form will be entered on the Central Register and available for disclosure according to the Assisted Reproductive Technology Act 2007.  APPLICANT DETAILS (details of the person who was born as a result of the surrogacy arrangement)						
First name:	TAILS (details of the person	who was born as	Middle name/s			
Last name:						
Date of birth: dd/mm/yyyy		Place of birth	:			
Residential address:	Street Address:					
	Suburb:			State:	Postcode:	
	Country: (only if not Australia)					
Postal address: (If different from residential address)	Street Address:					
	Suburb:			State:	Postcode:	
	Country: (only if not Australia)					
Your medical history and any genetic test results:						
Medical history and any genetic test results of the individual or the individual's family that are relevant to the future health of the birth parent or donor or any descendant's of the birth parent or donor.						
2. Details of ART provider and date of treatment:						
Name of the ART provider who performed the ART treatment and date of the treatment if known.						
Name of ART provider				Date of treatment		
3. Other information :						
Any other information you may wish to disclose to your birth parent or gamete donor.						

## RESTRICTIONS ON ACCESS TO THE INFORMATION (please indicate what restrictions (if any) you want to be imposed on access to information provided) Who may access to the information provided: 1. Birth parent? Yes ☐ No ☐ What information may be accessed by a birth parent? a. Your identifying information? No 🗌 Yes 🗌 No 🗌 Name: Yes 🗌 Address: Yes 🗌 Date of birth: Yes 🗌 No $\square$ Place of birth: No $\square$ No $\square$ Details of your medical history? Yes $\square$ Details of any genetic test results? Yes ☐ No ☐ C. № П Details of the ART provider and date of treatment? Yes d. e. Other information provided by you? Yes No 🗌 Donor of the gamete? Yes No What information may be accessed by the donor? a. Your identifying information? Yes 🗌 No $\square$ Yes $\square$ No $\square$ Name: Address: Date of birth: Yes 🗌 No $\square$ Place of birth: Yes 🗌 No $\square$ b. Details of your medical history? Yes No No Details of any genetic test results? Yes 🗌 No $\square$ C. d. Details of the ART provider and date of treatment? Yes $\square$ No 🗌 Yes 🗌 No $\square$ e. Other information provided by you? I declare that the above information is a true and correct record at the time of this application and consent to release of the information as indicated above. I am 18 years of age or older: Applicant's name: Date: \_\_\_/\_\_\_/ Applicant's signature: Post your completed application, together with certified copies only of documents that satisfy the 100 point identify check, to the address below by email or post. The list of identity check documents can be found at the bottom of the page 'Forms and information': Email to: MOH-ARTPHCU@health.nsw.gov.au Note: Email correspondence is preferred Postal Address: Regulation and Compliance Unit Legal and Regulatory Services NSW Ministry of Health Locked Mail Bag 2030 St Leonards NSW 1590

For assistance contact Regulation and Compliance Unit, Legal and Regulatory Services during business hours on (02) 9424 5955.