



**CATHOLIC ADOPTION SERVICES  
OF WASHINGTON STATE**

A PROGRAM OF CATHOLIC COMMUNITY SERVICES OF WESTERN WASHINGTON

100 23<sup>rd</sup> Avenue South | Seattle, WA 98144-2302  
206-328-5928 | 877-865-5944 | FAX 206-328-5975  
www.ccsww.org/adoption

**REQUEST FOR DISCLOSURE OF NON-IDENTIFYING INFORMATION  
AND  
HOLD HARMLESS AGREEMENT  
ADULT ADOPTED PERSON**

I, \_\_\_\_\_, hereby request disclosure of non-identifying information contained in the records held by Catholic Community Services of Western Washington, as per RCW 26.33.340. I understand that I will receive only non-identifying material from my record which pertains to me, my birth relatives and the general circumstances surrounding my involvement with CCS.

I realize that the information I have requested may contain very sensitive and potentially negative information about my background. I also realize that some of the individuals participating in the creation of these records may have recorded observations of judgments about me, my birth parents and/or my adoptive family which I may feel is inaccurate, insensitive or hurtful. I request the non-identifying information at my own risk. I will hold Catholic Community Services and any of its employees harmless for any liability for the disclosure of the contents of my records to me. I have read or have had read and explained to me this paragraph and I fully understand it meaning and effect.

Birth Date of Adoptee: \_\_\_\_\_

Adoptive Parents' Names: \_\_\_\_\_

Catholic Community Services Location: \_\_\_\_\_ Circle One  
Seattle Tacoma Everett Bellingham Vancouver

Dated: this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Place:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number (Day) (Evening)

\_\_\_\_\_ signed or attested before me

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Please complete and return this form with a check for \$150.00 payable to Catholic Community Services.  
Send the form and check to:

Catholic Community Services  
Adoption Services  
100 23rd Avenue South  
Seattle, WA 98144-2302

Upon receipt of the completed form and fee, we will order the file. We are usually able to review the file and provide the non-identifying background information within one week of receiving the file.

If you would like to discuss your request further or have questions, please feel free to contact me.

Sincerely,

Jim Legaz, MSW  
206-328-5747  
JimL@ccsww.org

Carol Ryan, MEd  
206-328-5921  
CarolRyan@ccsww.org