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The Uniform Adoption Act's Health Disclosure Provisions: A Model That Should Not Be Overlooked

MARIANNE BROWER BLAIR*

I. Introduction

In the vigorous public debate engendered by the recent approval of a new Uniform Adoption Act\(^1\) by the National Conference of Commissioners on Uniform State Laws (NCCUSL), the Act's comprehensive health disclosure provisions have been largely overshadowed by some of its more controversial sections. The 1994 Uniform Adoption Act's (UAA or Act) health disclosure provisions\(^2\) provide an excellent model for states to follow as they consider revisions to their current adoption statutes. It would be unfortunate if they get lost in the fray.

Legislation providing for the disclosure of nonidentifying health information is not a new idea. During the past two decades virtually every state has enacted laws providing for the disclosure of some medical information to adoptive parents, and many of these statutes authorize the release of information to adult adoptees and birth parents.\(^3\) The statutes governing health disclosure in many states, however, are currently not sufficiently comprehensive or rigorous. The UAA improves upon ex-

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1. The National Conference of Commissioners on Uniform State Laws first approved a Uniform Adoption Act in 1953. In 1969, NCCUSL approved a Revised Uniform Adoption Act, which was amended in 1971. The UAA referred to throughout this article was approved by NCCUSL at its annual meeting in 1994 and supersedes the Revised Uniform Adoption Act of 1969. UNIF. ADOPTION ACT, 9 U.L.A. 1 (West Supp. 1995).
2. The term "health disclosure" refers to the disclosure of nonidentifying information related to the medical and social history of an adoptee and the adoptee's biological family.
3. See Appendix A.
isting statutory disclosure schemes in many ways, such as the inclusiveness of the information to be disclosed; the timing of the disclosure; its provision for post-adoption supplementation, retention, and release of information; its immunity and confidentiality protections; and its provisions for sanctions and liability for noncompliance. The purposes of this article are to highlight these and other aspects of the UAA that would improve current law in many states; to suggest some additional, or in a few minor instances, alternative provisions the states might wish to consider; to discuss implementation issues; and to comment upon the interrelationship between the UAA's provisions for civil liability and the current status of the state courts' recognition of liability for nondisclosure under common law theories such as fraud and negligence.

II. The Critical Importance of Comprehensive Disclosure Statutes

During much of this century, it was common practice for adoption agencies to disclose very limited information about the medical and social background of a child and the child's biological family to adoptive parents. The consequences of this approach have often been tragic. In numerous instances, adopted children failed to receive appropriate

4. The movement to enact statutes requiring confidentiality in adoption began in the 1920s. These statutes typically mandated the sealing of adoption records and required a judicial finding of good cause to obtain access to them. Adoption Law and Practice §§ 1.03[4], 13.01[1][b], 16.01[1] (Joan H. Hollinger ed., 1988) [hereinafter Adoption Law and Practice]. Prior to that time, adoptions in America were often open. It was not uncommon for birth mothers to stay with the adoptive family during pregnancy. Adoptive families were often chosen by the birth mother's family. In fact, during the late nineteenth century, newspapers routinely reported details of adoption proceedings. Lincoln Caplan, An Open Adoption 85 (1990).

5. See, e.g., Arthur D. Sorosky et al., The Adoption Triangle 35-36 (1978); Adoption Law & Practice, supra note 4, § 13.01[1][b] and [c], 16.01[1]; American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Independent Care, Issues of Confidentiality in Adoption: The Role of the Pediatrician, Publication No. RE 9405 (1994); Karen Fernau, Lawsuits Filed over Adoptions, Information on Children Withheld, Parents Say, Phoenix Gazette, July 5, 1993, at 3 ("Conventional thinking before the mid-1980s was that the biological parents' rights to privacy often took precedence over adoptive parent's desires to have information released."); Rob Karwath, Teenager's Adoptive Parents Sue, Chi. Trib., Dec. 29, 1989, § 2, at 12 (David Sneidman, spokesperson for the Illinois Department of Children and Family Services, stated that prior to the enactment of the Illinois' disclosure law in 1985, the conventional wisdom of adoption agencies was that adopted children and parents were better off not knowing background information.). Cf. E. Wayne Carp, Adoption and Disclosure of Family Information: A Historical Perspective, 74 Child Welfare 217, 219, 225, 230 (1995) (author concludes that in the first half of the twentieth century the majority of adoption agencies disclosed what little family information was available, citing his own study of one agency's records; a
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psychiatric or medical treatment they desperately needed because medical information that was readily available was not revealed to the adoptive parents. As a result, children with psychiatric disorders that might have been successfully treated at a young age were ultimately institutionalized as adolescents. Some children mutilated themselves or at-

study of 30 agencies in 1937 that found the agencies evenly divided, half revealing all non-identifying information and the other half disclosing as little as possible to adoptive parents about background information; and another study in 1947 finding that 70% of the 95 agencies surveyed revealed whatever nonidentifying information they had. He further concludes that in the early 1950s, a marked change in philosophy among social workers and agencies occurred and agencies increasingly disclosed to adoptive parents only favorable medical and social information, or chose to reveal none at all.

6. Psychiatrists who work with children with "attachment disorder," many of whom exhibit psychopathic behavior, report that the chances of a successful therapy outcome are greatly increased if the child is diagnosed when young. For children over seven, the chances of success are only about 50%, and for children over age eleven, the likelihood of recovery is even lower. Ken Magid & Carole A. McKelvey, High Risk 149, 216 (1987). Knowledge of the occurrence of schizophrenia or manic-depression in biological relatives can hasten diagnosis and appropriate drug therapy.

Deborah Franklin, What a Child is Given, N.Y. Times, Sept. 3, 1989, § 6, at 36, 41 (After years of unsuccessful therapy, adopted daughter was diagnosed at age 17 with bipolar disorder, a condition the adoptive family later discovered afflicted her birth father. "Laura had so much pain and went undiagnosed for so long," her mother lamented. "She didn't just need family therapy. She needed lithium.").

7. See, e.g., David Postman, Sins of Silence, Seattle Times, Jan. 14, 1996, (News), at 6 (child whose violent past was undisclosed was subsequently institutionalized.); Diane Klein, An Adopted Boy-And Terror Begins, L.A. Times, Jan. 4, 1988, § 1 (Home), at 3 (Tommy Colella, whose diagnosis of fetal alcohol syndrome with psychotic behavior was not shared with his adoptive parents, was ultimately institutionalized. His adoptive mother observed, "[a]s awful as it was, we know that Tommy suffered more than we did. He was denied the treatment he needed. The system failed him."); Diane Klein, "Special" Children, Dark Past Can Haunt Adoptions, L.A. Times, May 29, 1988, § 1, at 1 (Social workers for years withheld an extensive family history of schizophrenia from the adoptive parents of "Monica," who endured years of inappropriate therapy and was ultimately institutionalized.); Karwath, supra note 5, at 12 (Adoptive mother of an institutionalized son who learned 12 years after the adoption that both birth parents had been institutionalized for mental problems, observed, "If we had had this information earlier maybe we could have been more aware of things to look for and gotten more expert help sooner."); Bonnie Jacob, Raising Cain, New Dominion, May-June 1989, at 36 (Adoptive father of institutionalized son suffering from fetal alcohol syndrome, from whom pre-placement evidence of organic brain damage was withheld, quoted as saying, "The cruel thing is that not knowing about John's condition has cost him so much time. Time we spent on therapies that didn't work, time wasted when doctors said, 'He's just a hyperactive, normal kid. He'll grow out of it.' Now it may be too late to help John, or it may take 10 times longer than it would have if we'd started right in the first place."); Daniel Golden, When Adoption Doesn't Work, Boston Globe, June 11, 1989, § 16, at 73 (Despite state psychiatrist's recommendation that child receive long-term psychiatric care instead of adoptive placement, child was placed for adoption, subsequently tried to kill adoptive father, and was ultimately institutionalized.).
tempted suicide. Some children with physical or genetic disorders underwent painful, expensive, and sometimes hazardous diagnostic testing that could have been avoided, or received improper medical treatment that delayed recovery, and occasionally resulted in permanent disability. Siblings in adoptive families have been raped, tortured, sexually molested, and threatened by adopted children whose parents were given no warning about similar past behavior and psychiatric problems of the child. Adoptive families without adequate information were left totally unprepared for, and emotionally devastated by their
children's destructive behavior, fire-setting, violence, and threats. In some families the extreme stress caused by this unanticipated behavior contributed to the deterioration of the adoptive parents' marriage or disruption of the adoptive placement. Although attempted adoption revocations are rare, they have increased as adoptive parents felt defrauded, betrayed, and helpless to meet the unexpected emotional and financial demands of their child's disorder.

Another family learned after their adopted daughter was ultimately institutionalized that she had sexually assaulted and tortured her adopted baby sister.); Jane Hadley, Parents Sue Over Adoptions, State Blamed for Failure to Disclose Children's Problems, SEATTLE POST-INTELLIGENCER, February 23, 1995, at 2 (adopted son sexually abused the adopted daughter of a King County Family); Patricia Miller, State Court Weighs Law to Protect Against Dishonest Adoption Agents, PITTSBURGH POST-GAZETTE, April 17, 1994, at 2 (After threats to their younger son, adoptive parents in McKean County, Pa. ultimately removed adopted son from their home, "fearing for the safety of their younger child"); Golden, supra note 7, at 79, (Jacob Clemons, in an apparent suicide attempt, killed his two younger brothers in a fire); Klein, supra note 7, at 1 ("Monica" tried twice to suffocate baby sister); Catherine Clabby, Adoption Woe, Parents Allege Sexual-Abuse Cover-Up, ALBANY TIMES UNION, Dec. 20, 1992, at A-1 (Adopted son sodomized an adopted brother). See also In re Robert S., 647 N.E. 2d 869 (Ohio App. 1994) (adopted son exhibited violent behavior to newly adopted baby brother).

12. See Andrea Sachs, When the Lullaby Ends, Time, June 4, 1990, at 82 (adopted son tried to cut off his cousin's arm, and on another occasion set fire to the cousin's room while he slept); Golden, supra note 7, at 16, 73, 82 (Adopted daughter set fire that almost burned the house down, stole, fought repeatedly with her parents and older sister, and tried to poison her father with Lysol. Tension was so high her sister's friends stopped coming over. Attacks by other adopted children also described.); Lisa Belkin, Adoptive Parents Ask States for Help With Abused Young, N.Y. TIMES, Aug. 22, 1988, at A1 (Adopted child attempted to burn down house and threatened younger brother with knife; attacks by other children also described.); Jacob, supra note 7, at 35 (previously well-adjusted sister began staying in her room behind closed doors due to adopted brother's behavior); Klein, supra note 7, at 16 (siblings lived in constant turmoil and fear because of violent behavior of adopted daughter "Monica").

In Colorado an organization founded for parents of adoptive children who are violent and mentally ill gained 2,000 members during its first five months. Belkin, supra, at A1.

13. Golden, supra note 7, at 82 (Parents of Lisa G., whose violent and destructive behavior ultimately led to her institutionalization, separated a few months after her adoption was revoked.); id. at 79 (One adoptive mother who leads workshops for adoptive families observed, "A lot of people stay in the [adoptive] commitment after it doesn't workout. And to me, that's really unhealthy because it affects the rest of the family. I've seen so many marriages break up over it."); Jacob, supra note 7, at 35 (reporting that stress related to son's behavior caused adoptive couple to fight continuously.); Fernau, supra note 5, at 4 (quoting one adoptive mother, "I love this boy so much that the idea of giving him up is the last, last, last resort. One neurologist asked me if I was willing to destroy my family to save a child that can't be saved. We just don't know the answer yet.").

14. The term adoption disruption is used by social scientists to describe any adoptive placement that has ended, whether before or after finalization. Disruption can cause a child tremendous instability and emotional upheaval, which can be permanently damaging, and diminishes the child's chances for successful adoption thereafter. Social scientists studying adoption disruption found that "Among families that reported no information gaps, the disruption rate was only 19%. Among families reporting one
Beginning in the late 1970s, experts in the field of adoption began endorsing full disclosure of health information to adoptive parents. Professionals who place children with special needs or who are at risk for medical problems have come to realize that providing prospective adoptive parents with the most complete information available is essential to ensuring that the family is both emotionally and financially able to cope with the challenges such a child presents. Moreover, adoption

or more gaps, the disruption rate was 46%." Bart & Berry, supra note 8, at 20, 108-09. See also K. Nelson, On the Frontier of Adoption: A Study of Special Needs Adoptive Families 74-75 (1985).

Between 1983 and 1987, 69 adoption annulments in California were attributed to fraudulent misrepresentation by a county agency regarding a child. Klein, supra note 7, at 32. Actions seeking annulment or revocation for failure to disclose medical information have been filed in several states in recent years. See Christopher C. v. Kay C., 278 Cal. Rptr. 907 (Cal. Ct. App. 1991) (Adoption revocation granted because adoptive parents had not been told prior to placement of child's serious mental illness and expert opinion advising against adoption.); M.L.B. v. Dep't of Health & Rehab. Serv., 559 So. 2d 87 (Fla. Dist. Ct. App. 1990) (holding one-year period in which to attack validity of adoption does not preclude motion to set aside adoption on grounds of alleged fraudulent concealment of child's psychiatric disorder); County Dep't of Public Welfare v. Morningstar, 151 N.E.2d 150 (Ind. Ct. App. 1958); In re Leach, 128 N.W.2d 475 (Mich. 1964); In re Anonymous, 213 N.Y.2d 10 (N.Y. Surr. Ct. 1961); In re Adoption of Haggerty, No. CA-741, 1991 WL 115978 (Ohio App.) (rejecting as not timely a motion to vacate an adoption decree on grounds of fraudulent nondisclosure of child's behavior and emotional problems); In re Adoption of T.B., 622 N.E.2d 921 (Ind. 1993) (Adoptive parent's request for revocation was refused because failure of county agency to reveal sexual abuse of child, who had threatened to kill adoptive mother, was a negligent failure to investigate and not fraudulent).

For accounts of other revocation actions based upon misrepresentation, see Klein, Special Children, supra note 7, at 1; Belkin, supra note 12, at B8; Golden, supra note 7, at 82; Klein, Adopted Boy's Hidden Past Led Family to Life of Terror, L.A. Times, Jan. 4, 1988, § 2, at 1; Marvelli, supra note 8, at 6 (attempted revocation); Miller, supra note 11, at 2 (pending revocation proceeding).

15. See Sorosky et al., supra note 5, at 36 (observing that the Child Welfare League of America (CWLA), a national affiliation of adoption agencies and publisher of adoption standards, has recommended since 1971 that adoptive parents be given nonidentifying medical and social background information); Carp, supra note 5, at 234 (reporting that in 1978, CWLA revised its standards and "eliminated completely the section on withholding adverse information from adoptive parents").


17. James A. Rosenthal, Outcomes of Adoption of Children with Special Needs, 3(1) The Future of Children: Adoption, 84-85 (1993) [hereinafter Adoption]; Nelson, supra note 14, at 48-49 & 85-86 ("Arguably the parents' own informed opinion about the suitability of a placement is one of the best predictions of outcome. The most effective preparation, then, does not merely educate parents; it enables them
professionals now understand that compiling and disclosing a complete medical and genetic history is vital to children with no apparent health problems at the time of placement, because accurate medical information is critical to proper diagnosis, treatment, and preventive measures throughout an adoptee’s lifetime. Adult adoptees also require accurate medical and genetic information to make informed choices about their own reproductive decisions. Post-adoption supplementation of medical information and disclosure to adult adoptees and birth family members provide protection not only to adoptees and their descendants, but also to siblings and others who are biologically related to an adoptee.

State legislatures responded during the 1980s by amending their adoption statutes to provide for the collection and disclosure of some health-related information during and subsequent to the adoption process. Despite their praiseworthy efforts and the consensus of most adoption professionals supporting this reform, however, inadequate...
disclosure of medical information remains a problem. The comprehensive collection and disclosure provisions of the UAA suggest many areas where current statutory schemes could be strengthened and, thus, merit serious consideration.

III. The Collection and Disclosure of Health Information During the Adoption Process

A. Compilation of Background Information

1. Scope of Information

An obviously crucial step in the disclosure process is the initial information-gathering stage, when medical and social history is collected. It is vital that this process be regulated by statute, which must specify in detail the type of information to be compiled. One of the strengths of the UAA is its comprehensive description of the information that should be obtained, found in section 2-106(a).

a. Child’s Medical History

First and foremost, this section requires a current medical and psychological history of the child. While this may seem patently obvious, many states’ disclosure statutes focus only on the medical history of the birth parents and omit reference to the child’s own history. This is a costly

23. See AMERICAN ACADEMY OF PEDIATRICS, supra note 5, at 1 (“All states require a medical and genetic history to be obtained at the time of adoption, but these histories are often incomplete and inaccurate.”). See also Miller, supra note 11, at 2-3 (Adoptive parents allege nondisclosure of emotional problems in 1990 adoption); Postman, supra note 11, at 1-4 (At least 14 families are bringing suit against DSHS in the State of Washington, alleging DSHS social workers failed to disclose crucial information about their adopted child’s psychological history, despite a state law in place since 1979 and DSHS regulations that required disclosure of mental, physical and sensory handicaps. “The law has since been made more explicit and expanded to require more disclosure.”); Fernau, supra note 5, at 1 (adoptive parents sued agency for failure to disclose records of birth mother’s retardation and psychological disorders in a 1988 adoption, despite a 1984 Arizona law requiring disclosure of health and genetic history.); Groze et al., supra note 17, at 418, 423 (many parents in 1992 study of adoptive families of children with or at risk of HIV reported that background information was insufficient).

Just this spring the author attended an adoption presentation in which a psychologist presented a case study of a recent local adoption in which an adoptive family had not been told of a child’s prior record of sexual misconduct, several siblings in the adoptive family were sexually assaulted by the child, the adoption ultimately disrupted, and the child was institutionalized.

24. U.A.A. § 2-106 (1994). For text, see Appendix B.

25. Currently the disclosure statutes of at least nine states, Alaska, Connecticut, Georgia, Kentucky, Missouri, New Hampshire, North Dakota, South Dakota, and Vermont, focus on the medical history of biological relatives and not the child. Presumably, these statutes were drafted with infant adoptions in mind. However, non-infant adoptions make up a large percentage of all nonrelative domestic adoptions. NATIONAL COMMITTEE FOR ADOPTION, 1989 ADOPTION FACTBOOK 4 (1989).
omission, as a large percentage of the problems, lawsuits, and disruptions caused by nondisclosure have occurred when information known to the agency about the child’s history, particularly relating to psychological disorders, was not transmitted to the adoptive family. Section 2-106(a) sets out in detail the information that the child’s history must include:

1. "[A]n account of the minor’s prenatal care, medical condition at birth, any drug or medication taken by the minor’s mother during pregnancy." Prenatal history and the history of labor, delivery, and neonatal evaluation are essential to risk assessment, diagnosis, and treatment of many subsequent problems. Knowledge of the consumption of drugs or medication during pregnancy can also alert health-care professionals to certain risks. While alcohol was probably intended by the UAA drafters to be included as a drug in this category, or to be reported under "addiction to drugs or alcohol" in section 2-106(a)(2), states may wish to specifically add "or alcoholic consumption" after "medication taken" in section 2-106(a)(1), to facilitate assessment of the risk of fetal alcohol syndrome. Presence of this syndrome is confirmed only by accurate information about the quantity and nature of the alcohol that the mother consumed during pregnancy. While specific reference to this in the statute is no guarantee of the accuracy of the response, it may at least ensure that the proper questions are asked. Information regarding any exposure by the birth mother during her pregnancy to toxic substances, fumes, or occupational hazards that could affect the health of the child, and the timing during the pregnancy of the exposure should also be included on the medical history form. States might consider adding a specific reference to this type of information in the statute or implementing regulations to ensure its inclusion.

2. "Any subsequent medical, psychological, or psychiatric examination and diagnosis, and . . . a record of any immunizations and

26. See supra notes 7-14 and accompanying text. See generally ADOPTION LAW AND PRACTICE, supra note 4, at §§ 16.02, .03, .04 (describing the factual bases of the many lawsuits that have been filed against adoption intermediaries for nondisclosure of health information).

27. See Don Hadley & Barbara Petterson, Family History Workshop, in GENETIC FAMILY HISTORY, supra note 9, at 100, 108; Renata Laxova, Minor Signs of Major Problems, in Genetic Family History, supra note 9, at 69, 72; American Academy of Pediatrics Comm. on Early Childhood, Adoption, and Dependent Care, Initial Medical Evaluation of an Adopted Child, Publ. No. RE 9219, 88 PEDIATRICS 642 (1991).


29. Laxova, supra note 27, at 72. Fetal alcohol syndrome, caused by consumption of alcohol during pregnancy, can cause neurological damage to the infant, which may include growth retardation, developmental delay, a small head, and particular facial characteristics. Id.

health care received while in foster care or other care." Over half of all children adopted through domestic unrelated adoption in the United States are over two years of age and over a fourth of these are special needs adoptions.\textsuperscript{31} When these children change caregivers by moving to an adoptive family, it is essential that their complete medical and psychological records travel with them to ensure continuity of care and to facilitate future assessment.\textsuperscript{32} Even for infants, transmission of the infant's complete medical records is essential. One newborn who went straight to his adoptive home from the hospital suffered irreversible brain damage because information on the status of his phenylketonuria testing was not effectively communicated.\textsuperscript{33}

3. "Any physical, sexual, or emotional abuse suffered by the minor . . . ; information concerning a judicial order terminating the parental rights of a parent, and a proceeding in which the parent was alleged to have abused, neglected, abandoned, or otherwise mistreated the minor, a sibling of the minor or the other parent." Information about prior abuse and neglect is critical to ensuring that a child receives proper diagnosis and treatment when subsequent mental, emotional, or behavioral problems develop.\textsuperscript{34} Recent litigation suggests that this type of information frequently has been withheld in the past, with devastating consequences for the child, who failed to receive effective therapy for the emotional and psychological scars created by the abuse he suffered or witnessed, and for the families who were totally unprepared to cope with the resulting behavior disorders.\textsuperscript{35} It is therefore crucial that this information be specifically required in the statute.

\textsuperscript{31} Kathy S. Stolley, Statistics on Adoption in the United States, in ADOPRION, supra note 17, at 29.

\textsuperscript{32} The primary drafter of the UAA, Professor Joan Hollinger, aptly referred to this information as the child’s "medical passport." Telephone interview with Joan Hollinger (Jan. 8, 1996). See generally American Academy of Pediatrics, supra note 27, at 643.

\textsuperscript{33} See Foster v. Bass, 575 So. 2d 967, 971-72 (Miss. 1990).

\textsuperscript{34} Psychologists are developing increasingly effective therapies for abused children, but proper implementation is aided by specific knowledge of the abuse. See John W. McInturf, Preparing Special Needs Children for Adoption Through Use of a Life Book, 65 CHILD WELFARE 373, 376, 378, 381 (1986). See also BARTH & BERRY, supra note 8, at 15 (observing that a child’s history of abuse is critical to pre-adoption assessment); Rosenthal, supra note 17, at 81 (A history of physical and particularly sexual abuse prior to adoption is a key predictor of increased risk for adoption disruption.).

\textsuperscript{35} See, e.g., Gibbs v. Ernst, 647 A.2d 882 (Pa. 1994) (failure to disclose significant history of physical and sexual abuse; subsequent to adoption child required permanent institutionalization for violent behavior); Reidy v. Albany County Dep’t of Social Services, 598 N.Y.S.2d 115 (N.Y. App. 1993) (adopted son, with history of prior sexual abuse unknown to parents, molested sibling); Forter v. County of San Mateo, Case No. 332 087, California Superior Court, San Mateo County, (settled in July 1992 for $1.45
4. "Information concerning a criminal conviction or delinquency adjudication of the minor." While it may seem odd to discuss this requirement in the context of the child's medical history, information regarding criminal behavior by the child can provide an important clue to the existence of undiagnosed emotional or psychological problems, as well as an indicator to prospective adoptive parents of the severity of behavioral problems to be expected. Because both inadequate background information regarding behavioral problems and unrealistic parental expectations are key factors that contribute to instability of an adoptive placement, it is imperative that prospective adoptive parents be provided information on the child's juvenile or criminal record when it exists. In addition, to better serve this interest, a medical or social history report form should also contain a specific inquiry about any behavioral problems the child has exhibited, beyond any juvenile or criminal record of the child's that may exist.

One important category not included in the UAA, which states may wish to consider adding to section 2-106(a)(1), is a reference to the child's developmental history. This would include such information as the age at which the child acquired certain basic gross motor, fine motor, language, and cognitive skills, information which is diagnostically useful for many neurological and sensory deficit problems.

b. Medical History of Birth Family

Section 2-106(a) also requires a medical and psychological history of a child's genetic parents and relatives. Information regarding any known disease and hereditary disposition to disease and addiction to drugs or alcohol by genetic relatives is specifically included within

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million, parents alleged failure to disclose history of abuse and psychological treatment); S. L. Wykes, Adoption Suit Ends in $1.45 Million Settlement, SAN JOSE MERCURY NEWS, July 9, 1992, at 1B; Griffith v. Johnston, 899 F.2d 1427 (5th Cir. 1990), cert. denied, 498 U.S. 1040 (1991) (Many of the Texas families who joined this suit alleged that the state agency withheld information about previous physical or sexual abuse experienced by their children, which they contend delayed proper treatment for their subsequent emotional problems and contributed to years of severely disturbed behavior.). See also Belkin, supra note 12, at B8; Junda Woo, Adoption Suits Target Agencies for Negligence, WALL ST. J., July 9, 1992, at 2 (Undisclosed child abuse is one of the most common allegations in litigation against adoption agencies for nondisclosure).


37. See generally Rae Sprague, Developmental Approach to Casefinding: Part 2, in GENETIC FAMILY HISTORY, supra note 9, at 95-99.

38. Knowledge of a history of alcoholism forewarns adoptees to be cautious about their own alcoholic consumption. Developmental psychologist Robert Plomin observes that it is just as important to tell an adoptee about an alcoholic birth parent as it is to disclose a history of genetic diseases. Adoptees who know of alcoholism in the family, he observes, and who see symptoms of alcoholism developing, are more likely to get help early. Franklin, supra note 6, at 41.
this category, as is information regarding the health of the birth mother and the health of each parent at the time of birth. The vast majority of current state disclosure statutes do require collection and disclosure of some medical history of the birth parents. It is important, however, that these statutes specify that psychological history be included, since this appears to be another area that has been susceptible to nondisclosure in the past and has generated much litigation. Moreover, many states currently neglect to require collection of health information regarding other biological relatives, as the UAA would mandate. This is a dangerous oversight, as many medical problems skip generations or may not be apparent from the medical histories of birth parents, who are themselves often young at the time of the birth.

States may wish to specifically include in their statutes a reference to information about whether the birth parents are related to each other.


41. For examples of current state disclosure statutes that fail to require health information on any biological relatives other than the birth parents, see, e.g., ALA. CODE § 26-10A-19 (1975); IND. CODE ANN. § 31-3-1-2 (West Supp. 1995); MD. CODE ANN. FAM. LAW § 5-328 (1991); N.J. REV. STAT. ANN. § 9:3-41.1 (West Supp. 1995).

42. For information on generation-skipping conditions, see Reiser, supra note 20, at 65-66. See Meracle v. Children's Servs. Soc'y, 437 N.W.2d 532 (Wis. 1989) (an adopted child whose birth father was only a teen at the time of her birth and had not yet exhibited the symptoms of Huntington's Disease, which the child ultimately contracted). While many genetic diseases are relatively rare, information on the history of more common diseases such as heart disease, cancer, and diabetes within a family have significant health planning benefits for an adoptee.
Children of incestuous relationships have an increased risk of genetically inherited disorders, and information of this nature has been withheld, at least to some degree, in the past.

c. Social History

An important requirement, and one often omitted, is the UAA’s mandate that information be collected on the social history of the child, and the child’s birth parents and relatives. Specific instructions are given by section 2-106 to include information regarding the child’s past and existing relationships with anyone with whom the child has regularly lived or visited. The more knowledgeable the adoptive parents are about relationships that were and are important to the child, the better they can facilitate an older child’s adjustment into the new family and support the child through the grieving process the child may undergo for birth family or foster family members. In appropriate circumstances, adoptive parents may wish to facilitate continuing contact with foster parents or birth relatives with whom the child desires to maintain a relationship. As an adolescent, an adoptee may desire this information as he or she works through identity development. Moreover, information concerning all previous foster and adoptive placements should be routinely provided to prospective adoptive parents so that they are fully informed of all factors affecting their own risk assessment.

It is also essential to specifically require, as does section 2-106(a), information concerning a child’s “enrollment and performance in school, the results of any educational testing, and any special education needs.” This information will facilitate appropriate educational placement once the child is in the adoptive home and help ensure special education needs are adequately addressed. Current disclosure statutes, often drafted with infants in mind, often fail to include reference to educational records. Information about the child’s talents, hobbies, and special interests would also be useful information to collect through the child’s social history form.

Although information regarding the social history of the birth family may be perceived by some as less essential, it is extremely important

43. American Academy of Pediatrics, supra note 27, at 643. See also Black, supra note 19, at 194-95; Lamport, supra note 10, at 114.
44. See M.H. v. Caritas Family Servs., 488 N.W.2d 282 (Minn. 1992) (agency revealed incest in family background but allegedly failed to reveal birth parents were siblings).
45. The number of previous placements is one predictor of adoption disruption. In addition, a child who has experienced one adoption disruption is at an increased risk for subsequent disruption. Rosenthal, supra note 17, at 79, 81; Barth & Berry, supra note 8, at 72, 156-57.
to fostering an adoptee’s sense of identity, which is critical to healthy emotional development. Moreover, information regarding the child’s racial, ethnic, and religious background, as well as a general description of the birth parents, can have future diagnostic significance, in addition to enhancing a sense of identity. Information on tribal affiliation, also required by section 2-106, is relevant to legal concerns regarding the Indian Child Welfare Act, but also will assist adoptees who may later wish to seek the benefits of tribal membership. Information on “the level of educational and vocational achievement of the minor’s parents and relatives and any noteworthy accomplishments,” may contribute to the adoptee’s self esteem, and in any event, combat the sense of “genealogical bewilderment” some adoptees experience.

One item of social history that enacting states may wish to consider revising slightly is the reference in section 2-106(a)(4) to “information concerning a criminal conviction of a parent for a felony. . . .” To the extent this reference is intended only to include felonies related to abuse or neglect by the birth parent of the child placed for adoption or a sibling or other birth parent, it is certainly appropriate, as discussed above. If it is intended to include all felonies, it may be overbroad. Some types of felony convictions would be relevant to other categories of information the act sets out, such as parental use of drugs or alcohol. Psychological impairment that produced the criminal behavior would be part of the parents’ medical history. Inclusion of criminal convictions that are unrelated to the child or the child’s development, however, may create a risk of stigmatization and identity problems for the adoptee that outweigh any benefits that might be gained.

46. See Black, supra note 19, at 203-05; Whitehouse, supra note 9, at 20.
47. Hadley & Petterson, supra note 27, at 103, 104. For example, Tay Sachs disease is prevalent among those of Jewish ancestry, cystic fibrosis is most common among Caucasians, sickle cell anemia most frequently afflicts African Americans, and spinal bifida occurs more frequently among those of Jewish descent. Extremely tall or short height of the birth parents may be a clue of a genetic disorder. Id.
48. Alaska currently requires collection and disclosure of information on tribal membership of birth parents. See Alaska Stat. § 18.50.510 (1994). Tribal membership of other ancestors may also provide an adoptee with important information about her heritage.
49. This term has been used in psychological literature to describe symptoms associated with identity conflict on the part of some adoptees, caused by their lack of knowledge about the medical, social, and ethnic background of their birth families. The term was originally used by H.J. Sants, who described it as a state of confusion and uncertainty in adoptees who had become obsessed with questions about their biological roots. H.J. Sants, Genealogical Bewilderment in Children with Substitute Parents, 87 Brit. Med. Psychol. 133, 133-41 (1964). See In re Assalone, 512 A.2d. 1383, 1388, n.5 (R.I. 1986) (summarizing testimony by expert witness Dr. Brandon Qualls); Caplan, supra note 4, at 82; Sorosky et al., supra note 5, at 113.
50. See U.A.A. § 2-106(a)(5), Appendix B.
51. See supra notes 34-35 and accompanying text.
When preparing a form for the collection of this social history, the drafters may wish to consider requesting information about the circumstances leading to the adoption. This will help adoptive parents better understand and cope with any resulting problems an older adopted child may experience and better prepare adoptive parents to deal with the inevitable questions that even those adopted as infants will ultimately pose. The form should require not only the age of the adopted child, but also the ages of the birth parents, other children of either birth parent, and the birth grandparents at the time of the adoption, as well as the gender of the other children of either birth parent. Nonidentifying information about the existence of the extended family of the birth parents and grandparents should also be included, so that the adoptee in later years will have a sense of his or her biological roots, which is important whether or not the adoptee ultimately desires to pursue a reunion with any of these birth relatives.

d. Information Necessary to Determine Eligibility for Subsidies

An important provision of section 2-106(a) is the final mandate bridging several of the categories described above, to provide "information necessary to determine the minor's eligibility for state or federal benefits, including subsidies for adoption and other financial, medical, or similar assistance." Inspired by Texas' disclosure statute, which has contained a similar provision for many years, this requirement reminds the agencies and attorneys responsible for collection and disclosure of medical and social history of their obligation to ensure that prospective adoptive families be provided with all of the information they need to apply for such assistance. Adoption assistance benefits play a vital role in facilitating the adoption of special needs children. The failure to provide adequate information can needlessly delay or subvert a family's eligibility for benefits that would otherwise enable a child to receive appropriate medical care and provide the family with social services that offer much needed support.

53. Adoption assistance benefits may include the payment of nonrecurring adoption expenses, regular cash payments, medical assistance, and social services such as respite care, specialized day care, and counseling, and are funded through federal programs under the Adoption Assistance and Child Welfare Act and through state programs. For an in depth discussion of these programs, see ADOPTION LAW AND PRACTICE, supra note 4, at ch. 9.
54. Id. at § 9.01(1).
55. In general adoptive parents cannot negotiate for federal benefits after an adoption is completed. However, parents are allowed to establish benefits retroactively if they can establish that they were not provided with accurate information about their child's condition or the availability of adoption assistance prior to finalization of the adoption decree. Some states also permit application for state adoption assistance after finalization, on the basis of preexisting conditions that were unknown to the prospective
2. Collection Process

The UAA, like the majority of current state statutory disclosure schemes, does not provide a great deal of direction regarding the collection process itself, perhaps leaving this topic to implementing regulations. Because the collection process is so crucial, states may wish to consider carefully codifying more detailed standards for this investigation. 56

a. Forms

Section 2-106(f) provides that an appropriate state department 57 shall be responsible for prescribing and distributing a form to collect the medical and social history information. Paradoxically, the Child Welfare League of America has criticized this provision as unduly burdensome for a state department. 58 This criticism is misplaced. Collection of comprehensive, accurate information, particularly concerning genetic conditions about which lay people may not be knowledgeable, will be facilitated by the development of a uniform written form that can be used statewide. Each state can designate the department that is best suited to this task. In all likelihood, it will be the department that is responsible for oversight of public adoptive placement within the state. While there is no denying that development or revision of a form can be time-consuming, in all likelihood these departments are already charged with this task for their own adoptions. 59 Moreover, preparation of the most difficult portion of the form, that dealing with medical and genetic history, has been greatly facilitated by the creation of a detailed Model Medical/Genetic Family History Form for Adoptions by the Education Committee, Genetics and Adoption Subcommittee of the Council of Regional Networks of Genetics Services (CORN), which is available upon request 60 and can be incorporated into the state's form.

adoptive parents prior to finalization. Id. at § 9.04(6). Nevertheless, experts caution that "in most cases, it is essential that prospective adoptive parents explore their child's eligibility for adoption assistance before finalizing the adoption." Id.

56. See OHIO REV. CODE § 3107.12 (Baldwin 1994) (example of a disclosure statute that does codify standards for the investigation in unusual detail).

57. U.A.A. § 1-101 allows each state to pick the appropriate department, such as a Department of Social Services, a Department of Health Services, or a Department of Children's Services.


59. For example, in Oklahoma, the Department of Human Resources is already required to prepare a referral packet of social, psychological, educational, medical, and legal documents, and Affidavits of Information Disclosure. Okla. Dep't of Human Services Reg. 340:75-15-60, -61.

60. This model form, completed in September 1994, contains a cover sheet for identifying information and then separate sections for obtaining information on the delivery and birth of the child, a medical/genetic family history from the birth mother, and a medical/genetic family history from the birth father. Copies can be obtained by
Agencies and intermediaries who desire even more detailed information than the state's uniform form should be allowed to supplement the standard form with additional pages.

b. Responsibility for Collection

Complete and accurate collection of medical and social history would be facilitated if states would define in their disclosure statutes the qualifications required for the person writing the medical history. Section 2-106(a) of the UAA appropriately puts responsibility upon the agency, when the adoption is handled by an agency, to furnish the written report with the medical and social background information the statute requires. Agencies have professional personnel who are already trained to handle difficult interpersonal situations and who have access to continuing education programs that can provide specialized training that will facilitate the collection of technical information, an outcome anticipated by the Comment to section 2-106. The Act would be strengthened if adopting states codify or include in their implementing regulations a requirement, or at least a recommendation that, whenever feasible, the information be collected by professional employees who have received this specialized training.

One drawback of section 2-106(a) is that in direct placement (i.e., non-agency) adoptions, the duty to furnish, and hence to collect, the information is on the "person placing the minor for adoption," which would be, contacting Joan Burns, M.S., M.S.S.W., Subcommittee Chair, Wisconsin Clinical Genetics Center, 1500 Highland Avenue, Room 331, Madison, Wisconsin 53706; 608/263-5611.


62. See Plumridge et al., supra note 18, at 213 (collection of genetic information "is a refinement of already existing social work skills and can be enhanced through specialized training").

63. "These provisions will encourage the development of protocols—like those being drafted by the American Academy of Pediatrics in cooperation with child welfare agencies and attorneys—for collecting information in a non-intrusive manner that respects individual privacy. These provisions will also encourage better training of medical personnel, social workers, and genetic counselors who are called upon to assist prospective adoptive parents in evaluating the needs of minor adoptees." Comment on U.A.A. § 2-106.

64. Carol Amadio, Wrongful Adoption—A New Basis for Litigation: Another Challenge for Child Welfare, J.L. & Soc. WORK 23 (Mar. 1989) (concluding that all adoption agency personnel responsible for placement in a direct or supervisory capacity must receive "routine instruction through staff development programs and in written policy guidelines on the importance of" disclosure and appropriate disclosure procedure).
according to section 2-101, the child's parent or a guardian expressly authorized by the court to place the child. The drafters of the UAA faced a dilemma, because the Act permits some types of assistance by a lawyer, a health-care provider, an agency, or another person in direct placement adoptions, but does not require such assistance. Unfortunately, placing responsibility upon a birth parent will be ineffective. Birth parents lack proper training and, quite appropriately, are not subject to the enforcement provisions of the Act. In order to ensure that the collection responsibility will be delegated to a skilled professional who can be held accountable, states should place ultimate responsibility for collection in direct placement adoptions upon the attorney, physician, or licensed social worker who assists as an adoption intermediary in the manner permitted by state law, or if there is no such intermediary, upon the attorney who represents the petitioners for adoption. Attorneys, physicians, and social workers are all licensed by the state, and subject to a professional

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66. See U.A.A. § 2-102(b) & (c).
67. U.A.A. § 7-105 provides for penalties for anyone, other than a parent, who intentionally refuses to provide information, and creates civil liability for anyone who fails to perform the duties required by U.A.A. § 2-106.
68. If a state enacts this portion of the UAA, the assistance permitted by an adoption intermediary will be governed by section 2-102(b) & (c). See supra note 66. Currently, direct private placement of children with unrelated prospective adopted parents is permitted in the District of Columbia and in every state except four: Colorado, Connecticut, Delaware, and Massachusetts. See ADOPTION LAW AND PRACTICE, supra note 4, § 3.04, at 28 (Cum. Supp. 1995). State laws currently vary tremendously in the scope of assistance non-agency adoption intermediaries are permitted to provide. See ADOPTION LAW AND PRACTICE, supra note 4, §§ 3.04[3], 5.01 to .14, 6.02 to .04.
69. Nonagency adoption intermediaries are typically attorneys or physicians. Some states, however, permit ministers and other persons to act as intermediaries. See ADOPTION LAW AND PRACTICE, supra note 4, at § 3.04[3]. The UAA itself permits any person or entity to act as an intermediary. See supra note 66, U.A.A. §§ 2-102(b), 2-101(11) (defining "person" as "an individual, corporation, limited liability company, business trust, estate, trust, partnership, association, agency, joint venture, government, governmental subdivision or instrumentality, public corporation, or any other legal or commercial entity"). While attorneys, physicians, and social workers have access to the training necessary to effectively collect medical history, other types of intermediaries may not. In these instances, and when no one is acting as an "intermediary," it would be preferable to have the responsibility for collection and disclosure of medical information delegated by statute to the attorney representing the adoptive parents in the adoption proceeding. Ultimately, this attorney's professional duty to her clients should include ensuring that an appropriate medical investigation has been completed and that full disclosure has been made to her clients. Therefore, the attorney for the adoptive parents is a logical candidate for undertaking the collection responsibility in the absence of an agency or other appropriate intermediary. See Kaye McLeod, Private Placement Adoptions, 28 FALL ARK. LAW 46, 50 (1994) ("A careful lawyer should thoroughly disclose the biological parent's available medical background."); Raymond W. Godwin & Kenneth Biedzynski, Liability for Wrongful Adoption Looms
code of conduct. Attorneys and social workers have access to specialized training for adoption through continuing education programs. Physicians, who would already have the medical expertise necessary to properly collect the history, could receive training about the legal requirements through medical professional training networks. As with agency adoptions, the statute or implementing regulations should require training appropriate for the type of profession involved, and should limit the professional intermediary's ability to delegate the collection responsibility if the attorney, physician, or social worker does not herself collect the information and prepare the report. A trained paralegal, a licensed social worker under contract, or a trained nurse in a physician's office might all have acceptable qualifications to collect the information for the intermediary.

c. Actions in Which Collection is Required

The UAA clearly specifies that the collection and disclosure requirements apply in both agency and nonagency adoptions. It is less clear that they apply to stepparent adoptions, which are covered by a separate article in the UAA, Article 4, that does not specifically reference medical background information. Concerns about an adoptive parent making an "informed choice" in stepparent or other adoptions by relatives may be less compelling, as familial connection often motivates these adoptions. Nevertheless, important considerations remain for collecting the medical and social background information regarding any parent whose rights will be terminated in any adoption, and their biological relatives. Although the spouse of a prospective adoptive stepparent would know the child's history and his or her own history, that parent's knowledge of the terminated parent's medical and genetic history may be incomplete. Since the adoption will terminate one parent's parental rights, and may terminate the right to visitation, the adopted child

Large, N.J. L.J., Sept. 12, 1991, at 7 (expressing opinion that attorneys representing adoptive parents in agency adoption could invite claims of legal malpractice if they fail to ensure the agency's medical report complies with statutory disclosure requirements); David Leavitt, Counseling Clients in Independent Adoptions 25-26 (1980) (emphasizing importance of obtaining complete health history from both birth parents for prospective adoptive parents, as part of role of counsel in nonagency adoption); Adoption Law and Practice, supra note 4, at § 6.04[2][i] (discussing role of attorney for adoptive parents in private placement adoption, including importance of obtaining background information). Only as a last resort, in cases in which there is no agency or professional intermediary, and in which the adoptive parents are not represented by counsel, should the duty to collect and furnish information be placed upon the person placing the child for adoption.

70. Visitation rights of a parent whose rights have otherwise been terminated in a stepparent adoption can be preserved under the Act only by agreement under limited circumstances. See U.A.A. § 4-113.
may lose contact with that birth parent and his or her relatives, and thus lose access to important genetic information. In other types of relative adoptions, the adoptive parents may be unfamiliar with the medical and genetic history of the "other" side of the child's birth family. While collection and disclosure requirements could be tailored by statute to exclude history of the stepparents' spouse, collection and disclosure statutes should not exclude stepparent or other relative adoptions altogether.

Although the scope of the UAA was limited to adoption actions, states may wish to consider requiring the collection of medical and social history in all juvenile actions in which termination of parental rights could be an ultimate disposition. Children who ultimately become available for adoption through involuntary termination have often lived with at least one birth parent for a substantial period of time, so birth parents have crucial information about the child's own health history, in addition to their own medical and social histories. Cooperation in the collection process may be far easier to obtain in the early stages of a juvenile proceeding than at a time subsequent to termination when an adoption is taking place. Moreover, collection of health history in all juvenile proceedings would ensure that this information would be subsequently available for the thousands of children who become available for adoption, but are never adopted. However, because section 2-106(e) provides a use immunity for information furnished as part of the medical and social history, it might be wise to delay collection of any information that could be related to the termination action until the prosecution has gathered the evidence to be used in the juvenile proceeding, so that the termination action is not affected by the collection of medical and social history. If information is difficult to collect from a parent subject to termination of rights in an adoption proceeding, section 2-106(c) provides that the court may request such a parent to supply the medical and social history information needed.

71. Social workers are instructed that the best time to get information may be upon initial contact with the agency, when a parent often depends upon the agency for a favorable report or a service, or at the time of initial contact with the court system, when the parent's fear of the legal proceedings may motivate cooperation. Diane Knight, Working With the Resistant or Reticent Client Workshop, in GENETIC FAMILY HISTORY, supra note 9, at 56.

72. One study in Michigan, for example, found that of 134 children who became available for adoption during a three month period in 1987, 52 (39%) had still not been adopted four years later in July of 1991. Binsfield Commission Report, supra note 17, at 40.

73. See U.A.A. § 2-106(e), Appendix B.

74. See U.A.A. § 2-106(c), Appendix B.
d. Manner of Collection

Section 2-106(a) requires that the written report on background information must contain all information "reasonably available from any person who has had legal or physical custody of the minor or who has provided medical, psychological, educational or similar services to the minor." The Comment to section 7-105 explains that the Act's requirement to "provide background information that is 'reasonably available' is intended to create a statutory duty to use reasonable efforts to obtain the information and to disclose the information that is collected to prospective adoptive parents."\(^\text{75}\) This legislative history is critical, because establishing a "duty to use reasonable efforts" better conveys the responsibility of the adoption agency or intermediary to actively seek out the required information as opposed to passively recording whatever information is offered. Verifying the existence of this duty will deter any temptation on the part of an adoption agency or intermediary to take a "see no evil, hear no evil, say no evil" approach, perhaps out of a misplaced concern that the less information they possess, the less they are obligated to disclose, and an erroneous belief that their risk of potential liability for negligent misrepresentation might somehow be minimized. Passive collection efforts obviously thwart the intended goal of the statute, which is to promote the collection of accurate and complete background information. State legislatures should consider establishing the "duty to use reasonable efforts" to obtain information in the statute itself, or in implementing regulations. At the very least, it should be incorporated in legislative comments or other legislative history, so that the meaning of "reasonably available" intended by the drafters of the UAA does not get overlooked by those attempting to comply with the Act or by courts later interpreting it.

The drafters of the UAA prudently subverted financial burden as an excuse for half-hearted collection efforts. Section 7-104, which regulates charges and fees by an agency, permits an agency to "charge or accept a fee or other reasonable compensation from a prospective adoptive parent for . . . expenses incurred in ascertaining the information required by Section 2-106. . . ." Similarly, section 7-103, which regulates lawful payments related to adoption, permits nonagency service providers to be paid for these expenses.

What do reasonable efforts include? Section 2-106 is far more comprehensive than most existing state statutes in its description of the persons from whom information must be sought. It requires obtaining information from anyone who has had legal or physical custody of the

\(^\text{75}\) U.A.A. § 7-105, Comment.
child and anyone who has provided medical, psychological, educational, or similar services to the child. Information from birth parents, foster parents, or others who have had physical or legal custody should be obtained by personal interview conducted by someone trained to collect the information. Trained professionals in an interview can ask follow-up questions and, by explaining the importance of particular information as well as confidentiality and immunity provisions, they may overcome an initial reluctance to disclose. Such explanations can be performed far more effectively in person than in print.

Reasonable efforts should also include obtaining a copy of all of the child's medical, psychological, and educational records. Obtaining a consent authorizing the release of these records from a parent or legal guardian should not be difficult when the parent or legal custodian voluntarily relinquishes a child for adoption. Children adopted following involuntary termination are normally in state custody, so the release could be signed by the appropriate state official. However, for the rare circumstances in which releases cannot otherwise be obtained, states may wish to include in their disclosure statutes a provision authorizing release of all of the child's medical and educational records to an agency placing a child for adoption, or to the attorney for petitioners for adoption in the case of direct placement adoptions. The agency or intermediary should retain one copy of the records for their files, and provide the prospective adoptive parents with a copy of all of the records, with identifying information redacted, if necessary, in closed adoptions.

Collection of medical, social, and genetic history directly from a birth father, preferably through personal interview, as well as from the birth mother, is important if complete and accurate information is to be obtained. Although section 2-106 mandates the collection and disclosure of medical and social information concerning both birth parents and their relatives, its provision that the information be obtained from persons who have had legal or physical custody could be misconstrued to suggest that information regarding putative birth fathers, who may never have had physical or legal custody, would be obtained only

76. The drafters of the Model Medical/Genetic Family History Form for Adoption indicate on the cover page that "it would be optimal if each birth parent was assisted in completing the questionnaires by a trained professional worker who appreciates the importance of collecting the information and has an awareness of the medical and genetic conditions contained in the form." See supra note 60 and accompanying text. Requiring a personal interview is strongly recommended by another social work professional who provides training to adoption social workers in Wisconsin. Thomas J. Mick, Social Work Practice Issues, GENETIC FAMILY HISTORY, supra note 9, at 34.

77. See supra notes 62-64 and accompanying text.

78. See Mick, supra note 76, at 34; Knight, supra note 71, at 57-58.
Health Disclosure Provisions

from the birth mother or the child's medical care providers. This clearly
was not the intent of the drafters of the UAA. In section 3-404, the
Act requires that a birth mother who is not forthcoming about the
identity or whereabouts of the possible father must be advised, among
other things, that "the lack of information about the father's medical
and genetic history may be detrimental to the adoptee," advice that
clearly implies that this information is to be obtained directly from the
father.

An often sensitive and difficult issue is the question of when the
medical and social background information should be obtained from
the birth father of a child born out of wedlock who is voluntarily placed
for adoption by the birth mother, without the birth father's direct partici-
pation. In most cases it is desirable for the birth father's medical and
social history to be collected in sufficient time prior to the birth or
placement to facilitate placement planning by the agency or intermedi-
ary and the adoptive parents. If information exists in the father's history
which could adversely affect some prospective adoptive parent's deci-
sion to adopt a particular child, it is in the child's interest for this to
be known as early as possible so that a stable placement can be made
with prospective adoptive parents who have made an informed choice
to adopt the child. Particularly in cases in which a birth father executes
a pre-birth disclaimer of interest under section 2-402, or some similar
pre-birth consent, medical and social history should be obtained from
the birth father prior to or at the time consent is given, if at all possible,
because the birth father may be difficult to locate, resistant to further
contact, or find the contact distressing after the consent is given.

In some instances, however, a birth mother will oppose contacting
the birth father prior to the birth and placement, out of fear the birth
father may harass or abuse her. An agency or intermediary should
have the discretion to obtain the information the birth mother knows

79. See U.A.A. § 3-404, Investigation and Notice to Unknown Father.
81. See TEX. FAM. CODE ANN. § 161.106 (1996) (permits a birth father to sign
a pre-birth affidavit disclaiming interest in the child, which waives a right to notice
and may be used as a basis to terminate parental rights in an adoption proceeding).
See also MICH. COMP. LAWS. ANN. § 710.34 (West Supp. 1995) (birth father served
with a pre-birth notice of intent to release child or consent to child's adoption must
file a notice of intent to claim paternity; failure to do so waives right to notice
and will result in termination of his rights in an adoption proceeding). Cf. IND. CODE ANN.
§ 31-3-1-6.4 (Supp. 1995) (permits pre-birth notice to birth father of possible adoption,
and implies father's consent if father fails to file a paternity action within 30 days
after receiving actual notice).
82. See Joan Heifetz Hollinger, Adoption Law, in ADOPTION, supra note 17, at
47.
about the birth father’s medical history at an early stage, and postpone collection of medical and social history directly from the birth father in appropriate cases, particularly when the birth mother fears abuse, until after the notice of the adoption proceedings is given to the birth father.

The terms of the UAA would appear to permit this flexibility. Section 2-106(a) provides that all information reasonably available from a legal or physical custodian of the child or a medical provider be furnished to prospective adoptive parents “as early as practicable before a prospective adoptive parent accepts physical custody” of the child, and further requires that, prior to a hearing on the petition for adoption, prospective adoptive parents be given a supplemental report with information that became available since the initial disclosure and placement. 83 Sections 3-401, 84 3-404, 85 and 3-70386 require that notice be given prior to the hearing on the petition to all putative fathers, including anyone who claims to be or is named as a father or possible father, and any previously “unknown father” about whom the court learns during the pendency of the adoption. Thus, in situations in which the agency or intermediary determines, due to a birth mother’s fear of abuse or harassment, that it is appropriate to delay efforts to directly collect information from the birth father until after he has received notice, that information could be included in the supplemental report.

The UAA has been criticized for its failure to force birth mothers to reveal the identity or whereabouts of the father. 87 Although the criticism is usually raised in the context of concern for the constitutional rights of the father or the finality of the decree, it could clearly be raised in the context of collection of medical and social information. Obviously, the inability to find the actual birth father prevents collection of medical and social history from him.

Certainly, birth mothers have on occasion refused to identify or help locate a birth father, or have misidentified the birth father. 88 The UAA recognizes the problem by requiring that anyone claiming to be or

83. See U.A.A. § 2-106(a), Appendix B.
84. U.A.A. § 3-401, Service of Notice.
85. See U.A.A. § 3-404, Investigation and Notice to Unknown Father.
86. U.A.A. § 3-703, Granting Petition for Adoption (1994).
88. See, e.g., In re Clausen, 502 N.W.2d 649 (Mich. 1993) (Baby Jessica’s birth mother identified a man who was not the birth father, who initially signed the consent); In re Petition of John Doe and Jane Doe to Adopt Baby Boy Janikova, 638 N.E.2d 181 (Ill. 1994) (Baby Richard’s birth mother initially refused to reveal the name of the birth father to the court). See also Dirk Johnson, Debate on Adoption is Focusing
named as a father or possible father, at any time in the proceeding be
given notice, and requires an investigation to identify unknown fathers
for the purpose of providing notice. Section 3-404 provides for publi-
cation or posting if it is likely to lead to the receipt of notice by the
father. Section 3-404 further requires that a birth mother who does
not disclose the identity or whereabouts of a possible birth father "must
be advised that the proceeding for adoption may be delayed or subject
to challenge if a possible father is not given notice of the proceeding
and that the lack of information about the father’s medical and genetic
history may be detrimental to the adoption." Section 7-105(f) also
provides for civil liability for a parent who knowingly misidentifies
the other parent "with an intent to deceive the other parent, an agency,
or a prospective adoptive parent. . ." Further "forcing" a birth
mother to disclose could presumably be done in only one of two ways:
(1) criminal sanctions for birth mothers who fail to reveal or incorrectly
name a birth father, or (2) deletions of the provisions in the UAA that
in some instances allow an adoption to be granted or remain in effect
or custody to be awarded over the objection of a "thwarted" birth
father. Regarding the first alternative, there is little evidence that
criminal sanctions would be effective in forcing disclosure, and jailing
a birth mother seems a harsh and inappropriate remedy. As to the
second alternative, the risk that an adoption could be prevented or
challenged is still present under the UAA and is one about which the
birth mother must be specifically counseled, in an effort to persuade

on Rights to See Family Histories, N.Y. Times, Feb. 11, 1990, § 1, at 36; Hollinger,
supra note 82, at 47, 58, n.27-28 and accompanying text; Adoption Law and Prac-
tice, supra note 4, at § 2.04[2].
89. See U.A.A. § 3-401.
90. See U.A.A. § 3-404.
91. See U.A.A. § 3-404(d).
92. See U.A.A. § 3-404(e).
93. U.A.A. § 7-105(f).
94. Under U.A.A. § 3-504, a thwarted father who failed to provide sufficient
support and visitation because he did not know of the child’s existence or could not
find the birth mother can still have his rights terminated if the court finds that failure
to terminate would be detrimental to the child. U.A.A. § 3-707 provides that a decree
of adoption may not be subject to a challenge begun more that six months after the
decree is issued. U.A.A. § 3-704 provides that if a petition for adoption is denied for
any reason other than the revocation of a consent or relinquishment, custody of the
child will then be awarded according to the best interests of the child.
95. A birth father, by the act of intercourse, has some notice that conception is
possible. Many, if not all states afford him an opportunity to protect his rights through
a paternity registry or some other method that does not require the mother’s cooperation.
See generally Adoption Law and Practice, supra note 4, at § 2.04[2]. Incarcerating
a birth mother, who has undergone the pain of pregnancy, childbirth, and her own
separation from the child, is an extreme and unfair response.
her to disclose his identity. Strengthening "thwarted fathers" rights for the purpose of motivating a birth mother to disclose, however, seems unlikely to be more effective than the risk the Act currently creates. Debate about the extent to which "thwarted fathers" should be permitted to challenge or veto, from the perspective of the constitutional rights of those fathers, is beyond the scope of this article. As to the effect of the UAA's "thwarted father" provisions on the collection of medical and social history, the concern motivating those provisions, which is to permit a child to remain in a home in which the child is bonded and secure, is not outweighed by the slight or ephemeral chance that more medical information would be obtained if "thwarted fathers" rights were strengthened.

96. The CWLA, in its critique of the UAA, suggests that "[t]he only way to ensure that the mother's failure to name the child's father is based on a true lack of knowledge and not other reasons is through counseling." CWLA, Analysis of the Proposed Uniform Adoption Act 9. The UAA does provide in section 2-404(c) that prior to execution of a consent or relinquishment a parent "must have been informed of the meaning and consequences of adoption [and] the availability of personal and legal counseling . . ."; U.A.A. § 2-405(d) requires that the person before whom a consent is signed must certify that the parent "was offered counseling services and information about the adoption." U.A.A. § 2-405(c) also provides that a parent who is a minor "must have had access to counseling and must have had the advice of a lawyer who is not representing the adoptive parents or the agency." U.A.A. § 2-404(c) requires that a birth parent "must have been informed of the meaning and consequences of adoption," and U.A.A. § 3-404 requires that a birth mother who refuses to disclose the whereabouts or identity of a birth father "must be advised that the proceeding for adoption may be delayed or subject to challenge if a possible father is not given notice of the proceeding and that the lack of information about the father's medical and genetic history may be detrimental to the adoptee." CWLA is critical of these provisions because they are not specific enough about the accessibility of the counseling, the qualifications of the counselors, who will pay for the counseling, and how counseling will be provided to mothers who cannot afford it. Id. at 1-2. Both adoption agencies and attorneys representing adoptive parents have financial interests in children becoming available for adoption, and provision for access to or information about free or low-cost counseling from trained professionals not associated with the adoption agency or the attorney for adoptive parents may be worth serious consideration by a legislature.

Once a birth mother has decided to place her child for adoption, however, it is not clear why counseling from professionals who are not associated with the agency or attorneys for the adoptive parents will be any more effective in attempting to persuade her to reveal the birth father's name. Perhaps the concern is that the adoption agency or attorney for the adoptive parents might be motivated to counsel a birth mother not to divulge the father's name, out of fear he will contest the adoption. Such conduct would be unethical if engaged in by either agency social workers or attorneys in independent adoptions. That is why U.A.A. § 3-404(c) is so important, because it imposes upon the court, whenever a father's identity is unknown, the responsibility to ensure that the birth mother is advised of the negative consequences of her refusal to disclose.

97. See Blair, supra note 21, at 743-69 (discussion in greater depth of privacy, efficacy, and other concerns related to the collection of health information).
B. Disclosure to Adoptive Parents

1. Mandatory vs. Discretionary Disclosure

Although the vast majority of state disclosure statutes currently mandate that nonidentifying background information "shall" be furnished to prospective adoptive parents, a few states still leave the disclosure of medical and social history information to the discretion of the adoption agency or other intermediary, or to the discretion of the court. It is critical that disclosure of nonidentifying medical and social history be mandatory in all states, in order to overcome the bureaucratic and financial pressures that may tempt social workers and other facilitators to withhold information or perform inadequate medical investigations. Requiring a court order for disclosure increases legal fees and leaves disclosure dependent upon the idiosyncracies of the judge to whom the application is made, who may or may not have expertise on adoption health-related issues. The UAA's section 2-106(a) takes the correct approach, by requiring that all reasonably available information concerning the medical and social history of the child and the child's birth family "shall" be furnished to prospective adoptive parents.

2. Timing of Disclosure

One of the most important provisions of the UAA is its requirement in section 2-106(a) that disclosure of all reasonably available background information be made to a prospective adoptive parent "as early as practicable" before the parent accepts physical custody of the child. Prospective adoptive parents are entitled to make an informed decision about whether to adopt a particular child before they and the child

98. See Del. Code Ann. tit. 13 § 924 (Supp. 1994) (permitting the department or a licensed adoption agency to release nonidentifying information to any of the parties; otherwise requiring a court order for release of necessary medical information); S.C. Code Ann. § 20-7-1780 (Supp. 1995).


100. The cost and effort required to obtain complete data, the financial pressure to place special-needs children quickly in order to conserve public agency resources, and the pressure to generate placement statistics, which affect state funding of some public agencies and generate revenue for private agencies and other intermediaries, all serve to tempt adoption intermediaries to disclose incomplete information. See Blair, supra note 21, at 714-18 (in depth discussion of these pressures and the extent of nondisclosure in the 1980s, even after most agencies endorsed full disclosure in theory).

101. See U.A.A. § 2-106(a), Appendix B.

102. States might wish to consider including as an additional requirement the provision in Texas' statute that the medical and social history report be provided as early as practicable before the first meeting of the adoptive parents with the child. Tex. Fam. Code § 162.005(e) (West Supp. 1996).

103. Comment on U.A.A. § 2-106.
have bonded. Many current disclosure statutes require only that medical and social history be provided prior to or upon issuance of the final adoption decree. Such late disclosure could operate to prevent a child from receiving much needed medical treatment in the often lengthy post-placement interim and would cause substantial pain to the child and the family if the placement is disrupted when the information is ultimately disclosed.

Wisely, section 2-106(b) further provides that "[b]efore a hearing on a petition for adoption, the person who placed a minor for adoption shall furnish to the prospective adoptive parent a supplemental written report containing information required by subsection (a) which was unavailable before the minor was placed for adoption, but becomes reasonably available to the person after the placement." This subsection imposes a continuing duty upon the adoption intermediary to acquire information not available prior to placement, which could occur on relatively short notice to the intermediary in some circumstances. Although it would be an unusual case in which information from the relinquishing birth parent, guardian, or other custodian would not be available prior to placement, medical records and information from nonconsenting birth parents, other relatives, and medical personnel may take longer to reasonably obtain in some instances. Section 2-106(b) appropriately establishes a reasonable deadline, the hearing on the petition, for disclosing additional information which becomes available through reasonable efforts.

3. MANNER OF DISCLOSURE

Section 2-106(a), (b), and (d) provide that the medical and social history information required to be disclosed to prospective adoptive parents, both prior to placement and prior to the hearing, must be contained in a written report, which must indicate who prepared the report. Reliance on verbal communication, particularly during the highly emotional period for adoptive parents between the notification that a child is available for adoption and placement, creates unnecessary opportunities for misunderstanding and memory lapse. Providing a written report permits the prospective adoptive parents to refer back and reflect upon its contents, and facilitates their opportunity to seek outside medical advice about medical risks that may have been identified. To protect the agency or other intermediary, it might be wise to

include in implementing regulations a requirement that receipt of the report should be acknowledged in writing by the prospective adoptive parents.\(^{105}\)

Section 3-305 of the UAA requires that prior to the hearing on the petition for adoption, a copy of any report containing information required by section 2-106, i.e., the medical and social history, must be filed in the proceeding. Requiring that the court file contain a copy of these reports will help assure adoptive parents that they will receive complete information and protect an agency or intermediary in the future if an issue should arise about whether certain information was communicated.

IV. Post-Decree Retention, Collection, and Disclosure of Health Information

Although the collection and disclosure of medical and social history information to prospective adoptive parents is a critical issue and clearly has generated the most litigation, it is equally important that state disclosure statutes adequately address the long-term retention and post-decree supplementation of health information and its disclosure to others with legitimate need for the information. The UAA addresses these concerns.

A. Retention of Records

Section 6-102(d) and (e) of the UAA require that all court records regarding an adoption, which would include the written medical and social history reports submitted in compliance with sections 2-106 and 3-305 and any supplemental information that is added to the court records, must be retained permanently by the court for ninety-nine years after the date of the adoptee's birth.\(^{106}\)

The UAA should impose the same requirement upon agencies and other adoption intermediaries. The UAA implies that agencies, attorneys or other professional providers of adoption services will routinely keep records of medical and social history, because the Act imposes confidentiality restrictions upon these entities\(^{107}\) and establishes a mech-

\(^{105}\) See Amadio, \textit{supra} note 64, at 30 (recommending that child welfare agencies, to avoid liability, should include in the disclosure report a place for adoptive parents to sign acknowledging receipt, that the forms should be signed and dated by both the disclosing social worker and the adoptive parents, and that more than one social worker witness the disclosure process). \textit{See also} \textsc{Tex. Fam. Code Ann.} \textsection{} 162.005 (West Supp. 1996) (A petition for adoption cannot be granted until the court file contains a copy of the medical and social history report signed by the adoptive parents).

\(^{106}\) U.A.A. \textsection{} 6-102, Records Confidential, Court Records Sealed.

\(^{107}\) See U.A.A. \textsection{} 6-102(e).
anism for post-decree disclosure by agencies.\textsuperscript{108} Moreover, the Act appears to mandate the retention of information and reports by adoption agencies concerning medical and social history through section 7-105(b), which creates a misdemeanor, punishable by fine or imprisonment, for any employee or agent of an agency who intentionally destroys any information or report regarding medical or social history.\textsuperscript{109} Since no time limit is prescribed for the agency, as is imposed upon a court in section 6-102(d), the establishment of a misdemeanor would appear to impose a requirement that agency records be kept indefinitely. Nevertheless, subsequent access to health-related information would be enhanced if the act clearly mandated permanent retention of all adoption records, including all background and supplemental medical and social history, by all public and private adoption agencies, private attorneys, and any other professional providers of adoption services. This modification could easily be made by states enacting the UAA without undermining its underlying goals.

The National Association of Social Workers has criticized the UAA\textsuperscript{110} for its failure to "mandate the keeping of records by non-agency parties." This defect is related to the broader deficiency discussed above\textsuperscript{111} regarding the Act's delegation of responsibility for furnishing the background information in non-agency adoptions to the person placing the child for adoption, which would be the child's parent or guardian. Realistically, requiring birth parents or lay guardians to retain records will be an ineffective mechanism to preserve or provide for supplementation of adoption records. While in some situations all members of the triad may stay in contact, in those instances the need to use records to transmit past or supplemental medical information would be obviated. In direct placement adoptions in which direct contact between the adoptive and birth families did not occur or is not maintained, any need to exchange information will not be accomplished by making the birth parent the repository of the records. The Act, in fact, recognizes

\textsuperscript{108} See U.A.A. § 6-103.

\textsuperscript{109} U.A.A. § 7-105(b) makes it a misdemeanor for an employee or agent of an agency, the court, or the State (Registrar of Vital Statistics) to intentionally destroy any record or report compiled pursuant to U.A.A. § 2-106, which regulates the disclosure of background information to adoptive parents, or which is authorized for release under Article 6, which would include the nonidentifying information about the adoptee, the adoptee's former parents, and the adoptee's genetic history that has been retained by the agency. See U.A.A. §§ 6-103 and 7-105(b). For text of § 6-103, see Appendix B.

\textsuperscript{110} Letter from Margaret L. Palmiter, Deputy Executive Director, National Association of Social Workers, to the National Conference of Commissioners on Uniform State Laws (June 28, 1994).

\textsuperscript{111} See supra notes 61-66.
this by acknowledging that supplemental information could be provided to attorneys or another professional provider of services. It would be strengthened by simply requiring that the attorney or other professional who serves as adoption intermediary should be responsible for the collection, disclosure, and retention of the original information and reports and should, in addition to the court, be required to retain any supplemental health-related information that is subsequently provided to it. Persons who have a right to subsequent disclosure of this information, who may have difficulty locating the court in which the adoption took place, would then have an alternate source of information.

A third alternative source of information could be a statewide centralized registry, operated by whichever department would be appropriate for the particular state. The UAA provides in section 6-106\textsuperscript{112} for the establishment of a statewide registry, but delegates to the registry only the task of administering the release of identifying information. Regarding nonidentifying information, the registry’s task is simply to assist individuals seeking information to locate the court or agency that would have the records, even when the court\textsuperscript{113} or agency is in another state.\textsuperscript{114} This role should accomplish the goal equally well, if the agency is required to retain records. A useful modification would be to require the registrar to also assist individuals in locating the attorney or other professional provider of services involved in non-agency adoptions.

To further facilitate post-decree access to health-related information, states may wish to consider including in their statutes or implementing regulations a provision that requires agencies, attorneys, or other professional providers of services who cease to operate or practice to transfer their adoption records to the department that oversees public adoptions within the state, so that they will not be destroyed.\textsuperscript{115}

\textbf{B. Supplementation of Information}

Information concerning the birth parents, other children of one of the birth parents, or other birth relatives that would have significance for future diagnosis, medical and psychological treatment, and

\textsuperscript{112} U.A.A. § 6-106, Statewide Registry.

\textsuperscript{113} In some states there may be some concern with providing parents whose rights have been involuntarily terminated with the location of the court in which the adoption took place, particularly if the court is in a small county in which the child might easily be located. Particularly states with small rural counties may wish to consider some alternative mechanism for birth parents or relatives in such situations to obtain or file supplemental health information without disclosing to them the location of the court.

\textsuperscript{114} See U.A.A. § 6-103(f), Appendix B.

\textsuperscript{115} An example of this type of provision is Tex. Fam. Code Ann. § 162.006 (West Supp. 1996).
childbearing decisions of the adoptee often surfaces after the pre-decree investigation has been completed. Similarly, information about hereditary disorders of the adoptee that are discovered after finalization might be of critical importance to the medical treatment or childbearing decisions of birth family members. States must provide appropriate mechanisms for the supplementation of adoption records to enable this type of information to be preserved and transmitted.

The UAA addresses this issue of supplementation in section 6-102(e), by requiring that "[a]ny additional information about an adoptee, the adoptee's former parents, and the adoptee's genetic history that is submitted to the court within the ninety-nine year period must be added to the sealed records of the court." This section further provides that additional information that is submitted to an agency, lawyer, or other professional provider of services must be kept confidential. This provision could be strengthened, as discussed above, if the Act instead required that the supplemental information be retained by the agency, attorney, or other professional intermediary who facilitated the adoption. If the Act is modified, as suggested above, to require preparation of the initial medical and social history report by an attorney or other professional in a direct placement adoption, then supplemental information should be submitted to and retained by the attorney or other professional provider of services who prepared the report.

Supplementation of critical medical information would be enhanced if section 2-106 were amended to add a provision requiring the preparer of the original report to advise the birth parents, any other persons who submitted information for the report, and the adoptive parents that additional information about the adoptee, the birth parents, and the adoptee's genetic history that becomes available can be submitted to the agency, attorney, or other person who prepared the report and, if the location is known to them, to the clerk of the court that issues the decree of adoption. Requiring the location of the court to be released to all birth parents or relatives who do not otherwise know it, however,

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116. See U.A.A. § 6-102(c).
117. See supra notes 61-66 and accompanying text.
118. Ohio currently requires the investigator that collects the medical and social history to "inform the biological parent, or a person other than a biological parent who provides information . . . of the purpose and use of the histories and of his right to correct or expand the histories at any time." OHIO REV. CODE ANN. § 3107.12(d)(3) (Baldwin 1994).

The Oklahoma legislature passed a similar provision this spring, requiring the preparer of the report to advise the birth parents, others who contribute information, and the adoptive parents that additional information may be submitted to the one who prepared the report, or the clerk of the court. The statute specifically provides that the location of the court is not to be revealed if it is not otherwise known. 1996 Okla. Sess. Law Serv. ch. 297, § 4 (West), to be codified at OKLA. STAT. tit. 10, § 60.5B.
would be ill advised. Particularly when an adoption follows the involuntary termination of parental rights of a parent who contested the termination, as frequently happens in adoptive placements made by state agencies, release of the location of the court, if the county of the adoptive parents' residence is small, could facilitate subsequent location of the child and create a potential for risk or harassment. ¹¹⁹

Finally, access to supplemental information would be enhanced if agencies, attorneys, or other providers of professional services who receive supplemental information were to be required by statute to file a copy of the supplemental information with the clerk of the court that issued the decree of adoption, so that the court records would contain all of the information currently available. Similarly, the clerk of the court should be authorized to release a copy of the supplemental information filed with the court, upon request, to the agency, attorney, or other professional provider of services who prepared the original report, if they are required by modification of the present Act to retain their adoption records.

C. Post-Decree Disclosure

1. Who Is Entitled to Disclosure

The UAA recognizes that prospective adoptive parents are not the only ones with a genuine need for nonidentifying information about the medical and social history of an adoptee, the birth parents, and the adoptee's genetic history. Section 6-103¹²⁰ permits the court that granted the adoption or the agency that placed the child for adoption to furnish this information upon request to "an adoptive parent or guardian of an adoptee, an adoptee who has attained eighteen years of age, an emancipated adoptee, a deceased adoptee's direct descendant who has attained eighteen years of age, or the parent or guardian of a direct descendant who has not attained 18 years of age." Information that should be furnished includes both the reports prepared in the pre-decree investigation pursuant to section 2-106 and any additional information submitted to the court or the agency after finalization.

Each person entitled to disclosure under the Act has a legitimate need for medical information. Adoptive parents would already have a copy of the pre-decree reports, but would need access to any supplemen-

¹¹⁹. Employees of Oklahoma's Department of Human Services have described at a meeting attended by this author the extensive efforts of some biological relatives to locate children who had been placed for adoption subsequent to involuntary termination of their parents' rights due to abuse. While access to health information is important, it obviously cannot be accomplished in a manner that would put a child at risk.

¹²⁰. U.A.A. § 6-103, Release of Nonidentifying Information. For text, see Appendix B.
tal information provided by birth relatives that might affect future diagnosis or treatment for their child. Guardians of the adoptee would share the same interest and would need both the initial reports and any supplemental information. Some states may wish to limit the right of disclosure, however, to adoptive parents or guardians of adoptees who are under the age of eighteen or incompetent. As Ohio has recognized in its disclosure statutes, a competent adult adoptee is responsible for his or her own medical care and release of information to adoptive parents of an adult may invade the privacy interests of the adoptee.

Obviously, adult adoptees and those who have been emancipated have a critical interest in both the information in the initial reports, which may not have been provided to them by their adoptive parents, and in any subsequent information. Not only will the information assist them in obtaining appropriate medical care; it may also affect their own childbearing decisions.

An adult direct descendant of a deceased adoptee or the parent or guardian of a minor direct descendant of a deceased adoptee have a strong interest in information about hereditary factors or familial predisposition to disease that could be relevant to their own medical diagnoses, treatment, and childbearing decisions. Unlike descendants of unadopted ancestors, the descendants of adoptees often have no access to other biological relatives who could provide this information. On the other hand, the UAA may be overbroad in permitting descendants access to social history. While social history may be of interest, if the information will not affect medical care or childbearing decisions of descendants, the privacy interests of the deceased adoptee may outweigh descendants’ interests in information the adoptee has chosen not to share. The UAA may also be overbroad by allowing parents or guardians of minor descendants access to all medical and social history if the adoptee is still alive. In most cases the adoptee would willingly share information relevant to the medical care of his or her child. In situations where that does not occur, parents or guardians of children of unadopted persons cannot simply obtain copies of a parent’s medical or psychological records upon request. Allowing this disclosure to parents or guardians of children of all adoptees without a court order invades the privacy interests of the adoptee.

In two situations, however, the UAA should be modified to permit more expansive disclosure. Under the current Act, birth parents or

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121. Ohio Rev. Code Ann. § 3107.17(D) (Baldwin 1994) ("During the minority of the adopted person, only the adoptive parent of the person may inspect the forms. When an adoptee reaches majority, only he may inspect the forms.").

122. For further discussion of this issue, see Blair, supra note 21, at 687-95, 727-28.
birth siblings are entitled to disclosure of a serious health condition of an adoptee or the adoptee's direct descendant only if the court receives a certified statement from a physician explaining in detail why the condition should be disclosed to enable the parent or sibling to make an informed reproductive decision. When such a statement is received the court is directed to make a diligent search to notify the birth parents or siblings that such information is available. While requiring a search in such circumstances is an excellent provision, biological relatives should have access to information under broader circumstances. If an adoptive parent or adult adoptee submits to a court, agency, or adoption intermediary genetically significant information about the adoptee, then obviously the adoptive family or adult adoptee wants the birth relatives to have this information and believes it may be important to their health or childbearing. In such circumstances, a biological parent or other biological relative should be able to obtain this information from the court, agency, or intermediary upon request, without requiring the adoptive parent or adoptee to obtain a certified physician's statement. While the statement may well be an appropriate prerequisite for the initiation of a search, it should not be a prerequisite to simple access. Moreover, it is appropriate to transmit information that affects the health care of biological relatives, and not just their childbearing decisions.

Another category of disclosure relates to information about people whose birth mother's and birth father's rights were terminated and who were never adopted. The UAA, because it was intended to address only adoptions and not other juvenile proceedings, understandably considered this beyond the scope of the Act. Nevertheless, states enacting the UAA can incorporate disclosure provisions that serve the needs of this group and their families as well. An adult whose parents' rights were terminated and who was never adopted has the same need for medical and social history that an adult adoptee has, and similarly, often has no access to it directly from biological relatives. Foster parents

123. See U.A.A. § 6-103(c), Appendix B.
124. The American Adoption Congress has criticized the UAA for its failure to include provisions for disclosing information to nonadopted siblings and grandparents, as well as to spouses. American Adoption Congress, Statement in Opposition to the Uniform Adoption Act of 1994. While privacy interests of adoptees must be respected with regard to information released to their spouses, the disclosure to biological siblings and grandparents of genetically significant information purposely submitted by adoptive parents or an adult adoptee for transmission does not invoke the same privacy concerns. See supra note 122 and accompanying text.
125. See supra note 72 and accompanying text (discussing the need to collect health information regarding unadopted children whose parents' rights have been terminated).
or other guardians of a child whose parents' rights were terminated have a similar need for this information. The adult direct descendant of a deceased person whose parents' rights were terminated and the parent or guardian of a minor descendant of such a person have the same need for medical information as do descendants of adoptees. The biological relatives of a person whose parents' rights were terminated also may have a legitimate need for genetically significant information. Some states currently address the needs of this group.126

Finally, because supplemental information that is not submitted to the agency or an attorney in a direct placement adoption can be filed with the court and because even the initial reports could become lost or accidentally destroyed, the court should be permitted to provide a copy of all medical and social history information to the agency that placed the child or, in a direct placement adoption, the attorney for the adoptive parents or other professional intermediary who is retaining records of the adoption.

2. WHO IS ENTITLED TO DISCLOSE

Currently the UAA permits only the court that granted the adoption or the agency that placed the child to disclose even nonidentifying information. In direct placement adoptions, the attorney for the adoptive parents or another professional provider of services that prepared the reports or acquired supplemental information should be permitted to disclose it within the other guidelines imposed by the Act.127

3. MANNER OF DISCLOSURE

The UAA has drawn criticism128 for its requirement that all disclosure other than the initial pre-decree reports to prospective adoptive parents shall be given in the form of "a detailed summary of any relevant report or information that is included in the sealed records of the court or the confidential records of the agency." The Act further provides that the summary must exclude identifying information concerning an individual who has not filed a waiver of confidentiality with the court or agency.129 The Act's concern for confidentiality in closed adoptions

127. See supra notes 65-69 and accompanying text.
128. Child Welfare League of America has objected to the fact that an adoptee is entitled only to a summary of what the file contains, and complains that "[t]he act fails to specify who will make such a summary, who will determine what is to be included in that summary, and how that summary is to be presented. CWLA, supra note 58, at 8.
129. See U.A.A. § 6-103(b), Appendix B.
can be served in a less limiting manner. To avoid situations in which the person who prepares the summary excludes important information, this section of the UAA should be modified by the states to allow the disclosure of copies of the original reports, records or information, and require that any identifying information about birth parents, the adoptee, or adoptive parents be excised if waivers of confidentiality have not been filed by those parties whose identity would otherwise be revealed.

The Act does create in section 6-105 the right to petition the court to obtain information that is not available simply upon request under section 6-103. Those permitted to petition include an adult adoptee, an adoptee under the age of eighteen with permission of an adoptive parent, an adoptive parent of an adoptee under eighteen, an adult direct descendant of a deceased adoptee, the parent or guardian of a direct descendant who is not yet eighteen years old, and a birth parent. Essentially this section provides for the good cause hearing that was available prior to the enactment of modern disclosure statutes. It is still very useful for those situations that warrant disclosure and are not addressed by the general disclosure sections. The right to file for a good cause hearing, however, should at the least be extended to other biological relatives beyond birth parents. Allowing medical caregivers to directly petition a court in situations in which the adult adoptee, adoptive parents or guardian of a minor adoptee, or patient who is directly related to the adoptee is not capable of requesting the information directly may be useful in emergencies.\textsuperscript{132} Because section 6-105 requires findings of a compelling reason for disclosure and that the benefit to petitioner outweighs the harm of disclosure to anyone else, the right to file a petition for a hearing could safely be extended to anyone, it would seem, thereby allowing the court to address any unique circumstances not anticipated by the drafters of the Act.

An excellent provision in the Act’s disclosure sections is the requirement that the court make a diligent effort to notify an adult adoptee, the adoptive parent of a minor adoptee, and the direct descendant of a deceased adoptee of the availability of information about a health condition that may seriously affect the health of the adoptee or a direct descendant, if that risk is explained in detail in a certified statement from a physician. A similar requirement for a search for a birth parent or sibling to communicate the availability of information of a serious condition of the adoptee or direct descendant that would affect reproduc-


\textsuperscript{131} See Blair, supra note 21, at n.4 and accompanying text.

\textsuperscript{132} See Blair, supra note 21, at n.261-62 and accompanying text.
tive decisions of the birth parent or sibling was discussed above. The requirement that the court take proactive steps in these circumstances is essential.

To facilitate these searches, states may wish to consider providing that adoptive parents, birth parents and siblings, adult adoptees, descendants of adoptees, guardians of adoptees, and parents or guardians of descendants may all file with the clerk of the court in which the adoption is granted a notice of the individual's mailing address (specifying that this provision does not entitle birth relatives a right to knowledge of the location of the court if the location is not otherwise known to them). Access to information would be further enhanced if states chose to expand the notification concept to provide, in addition to the search provisions, that whenever supplemental health information is filed with the court, the court clerk shall notify the appropriate person by ordinary mail if the person's address is on file with the court clerk. Similarly agencies or intermediaries who receive supplemental information could be required to furnish copies to adoptive parents, adult adoptees, or birth parents when the appropriate individual's location is known to the agency or intermediary.

V. Efforts to Enhance Compliance: Immunity, Confidentiality, Sanctions, and Liability

A. Immunity

Section 2-106(e) of the UAA provides that information furnished for the preparation of the preplacement and prehearing reports on medical and social history cannot be used as evidence in any civil or criminal proceeding against the person who is the subject of the information. This is a use immunity, which precludes only the subsequent use of the testimony, i.e., the statements given to the agency or other person preparing the reports, and any evidence obtained by using the immunized statements or records. It is not a transactional immunity, which protects a witness from prosecution for those transactions about which the witness testified under the immunity. The purpose is to foster more accurate responses on such critical issues as drug or alcohol

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133. See supra notes 123-24 and accompanying text.
134. The Oklahoma legislature recently adopted legislation containing similar provisions. 1996 Okla. Sess. Law Serv. ch. 297, § 5 (West), to be codified at OKLA. STAT. tit. 10, § 60.5C.
135. See U.A.A. § 2-106(e), Appendix B.
137. Id.
consumption during pregnancy and physical or sexual abuse. The prosecution of mothers for substance abuse during pregnancy and the emerging recognition of civil liability to a child against a biological mother for prenatal injury due to negligence prompted the creation of this immunity.\textsuperscript{138} Caution must be taken in juvenile proceedings in which termination of parental rights is a potential outcome to gather medical and social history after the prosecutor has gathered the evidence of abuse to be used in the juvenile proceedings, so that the immunity does not inhibit the termination proceeding in cases in which the child would otherwise be at risk.\textsuperscript{139}

**B. Confidentiality**

To facilitate the collection of accurate medical and social history and to protect the right of privacy of birth relatives and the child whose intimate medical and psychological problems are often contained in reports of this history, it is important that disclosure of medical and social history records and reports be limited to those with a legitimate interest who are specifically authorized by the statute to receive it. The UAA provides this protection, in section 6-102(a), which declares that all records, whether on file with the court, an agency, or a state department such as a Registrar of Vital Statistics, are confidential and may not be inspected except as provided in the Act.\textsuperscript{140} This confidentiality requirement is repeated in several places throughout the Act.\textsuperscript{141}

\textsuperscript{138} Unif. Adoption Act § 2-106, Comment, 9 U.L.A. 18 (West Supp. 1995); Blair, supra note 21, at 765-68.

\textsuperscript{139} Blair, supra note 21, at 767-68.

\textsuperscript{140} See U.A.A. § 6-102.

\textsuperscript{141} U.A.A. § 6-102(d) requires that all court records be sealed for 99 years after the date of the adoptee's birth and not open to inspection to anyone except as provided in the Act. U.A.A. § 6-102(e) requires that additional information that is submitted to an agency, lawyer, or other professional provider of services be kept confidential. U.A.A. § 7-106 provides that the agency or other person who prepares and discloses reports or records regarding an adoption cannot disclose any identifying or nonidentifying information contained in the reports or records except as authorized by the Act and creates criminal and civil penalties for unauthorized disclosure of identifying and nonidentifying information made confidential by the Act.

Other provisions of the Act also protect the confidentiality of identifying information, unless confidentiality has been waived. U.A.A. § 2-106(d) specifically requires that medical and social history reports be edited to exclude the identity of any individual who furnished information, or about whom information is reported, unless confidentiality has been waived. See Appendix B. U.A.A. § 6-103 requires that other disclosures of nonidentifying information exclude identifying information concerning anyone who has not filed a waiver of confidentiality with the court or the agency. See Appendix B. U.A.A. § 6-104, which permits the disclosure of identifying information, does so only when the disclosure is authorized by the persons involved.
These provisions of the Act have been misconstrued by some critics of the Act, who disagree with the UAA's provisions limiting the release of identifying information, a topic beyond the scope of this article. Concerned United Birthparents and the American Adoption Congress have both publicly taken extreme interpretations of the Act, stating that it would penalize the sharing of information by adoptive and birth families who have voluntarily agreed to share it. This is simply not a reasonable construction of the confidentiality provisions of the Act. Their purpose was not to strangle dialogue among members of the adoption triad that is consensually open. In fact, both sections that address disclosure of health-related information, sections 2-106 and 6-103, specifically provide that identifying information must be excluded from the nonidentifying information disclosed only when it concerns an individual who has not waived confidentiality. The confidentiality provisions of the Act require those who prepare and retain the records, court and agency personnel, and other professional providers of services, to keep the information in the records and reports confidential. Their purpose is to prevent such people from sharing with members of the public personal information about health, psychological problems, or private information from the social histories concerning members of the birth family and the adoptee. A second purpose is to prevent disclosure of identifying information between members of the adoption triad when they have not consented to the disclosure. While these critics

142. Concerned United Birthparents gave this interpretation of an earlier draft (Mar. 20, 1994) of the Act:

Anyone who "assists in . . . obtaining . . . identifying information contained in a report or records . . . is guilty of a misdemeanor for the first violation and of a felony for each later violation." Note that criminal liability is not limited to people who get this information from a sealed record. Even if the information is obtained independently, such as being next door neighbors, the person could be subject to criminal penalties. A civil penalty would apply to a person who reveals or obtains nonidentifying information that is contained in a report or record under this Act even when the information is not obtained from such a report or record. There is no exception for open adoptions in which the birth and adoptive parents have met and visit each other. A birthmother who knew the adoptive parents could not tell her parents, spouse or subsequent children their identity (or her child's) since such a disclosure is not authorized by the Act. Adoptive parents could be arrested for telling the child that the woman sitting next to him at his birthday party is his birthmother. Id. at 2.

Letter from Janet Fenton, President, & Carole Anderson, Vice President, Concerned United Birthparents, to Commissioners, National Conference of Commissioners on Uniform State Laws (June 7, 1994).

143. The American Adoption Congress, in its Statement in Opposition to the Uniform Adoption Act of 1994, also interprets the Act to mean that "the sharing of any information by any of the participants becomes a criminal offense." Id. at 3.

144. See U.A.A. §§ 2-106A & 6-103, Appendix B.
may legitimately adhere to the position that all adoptions should be open and reject the UAA for permitting closed adoption, their interpretation that the confidentiality provisions prohibit the voluntary exchange of medical or social history in an open adoption is a distortion of the Acts' provisions.

States may have other confidentiality statutes that need to be examined to facilitate the goals of the Act. For example, while there seems to be total agreement that a prospective adoptive family should be informed if a child is known to have AIDS or HIV infection, or is at risk of HIV infection, and in fact such disclosure is in all likelihood occurring, some states may need to revise their HIV confidentiality protection statutes to specifically permit such disclosure. Similarly, states may wish to consider whether an exception should be created, and if so, under what circumstances, to permit disclosure of a birth mother's HIV infection or AIDS without her consent. Confidentiality statutes addressing other venereal diseases present similar issues. Maternal syphilis during pregnancy, for example, can have devastating health consequences for a child, and the release of information that signals a risk can prompt treatment by penicillin that would prevent impairments to the child from occurring.

C. Sanctions

Section 7-105(a) authorizes the imposition of civil monetary penalties against anyone other than a birth parent who has a duty to disclose nonidentifying medical and social history through initial reports under section 2-106 or under the subsequent disclosure provisions of the Act and intentionally refuses to provide the information. Courts are authorized to enjoin further violations of the duty to furnish nonidentifying information. Section 7-105(b) makes it a misdemeanor for an employee or agent of the court, agency, or state registrar to intentionally destroy information and reports compiled pursuant to the initial health disclosure statute, section 2-106, or authorized for subsequent disclosure. Anyone who knowingly tries to buy or sell nonidentifying information

145. See Groze et al., supra note 17, at 411.
147. See Blair, supra note 21, at 753-62.
148. Francis Livingston, Sexually Transmitted Diseases in Pregnancy, STD BULL., Apr. 1990, at 3, 3-10 (congenital syphilis can cause mental retardation, blindness, deformities, blood disorders, and death). See Blair, supra note 21, at 757-58.
149. Center for Disease Control, Sexually Transmitted Disease Treatment Guidelines, 38 MORBIDITY AND MORTALITY WkLY. REP. 10-11 (Supp. 8 1989).
that is not authorized for such disclosure under the Act is also subject to civil monetary penalties, as is a person who makes an intentional unauthorized disclosure of nonidentifying information. Any agency, entity, or person who makes or obtains an unauthorized disclosure can also be enjoined and a court is specifically authorized to refer such an agency, entity, or person to an appropriate licensing authority for disciplinary proceedings. The availability of these sanctions should have a deterrent effect upon individual employees, agencies, and other intermediaries who are tempted to intentionally withhold information or breach the confidentiality required by the Act.

D. Liability

1. Creation of a Statutory Cause of Action

Section 7-105(c) creates civil liability for damages or equitable relief in favor of an adoptive parent, an adoptee, or any person who is the subject of the information required to be collected in the initial medical and social history reports or authorized to be submitted and retained after finalization, for failure to perform any of the duties connected with the collection, retention, and disclosure of information required by the Act. The only entities subject to this civil liability under the present statutory scheme, however, are an agency or a guardian who places a child for adoption. Because the statute currently does not place responsibility for collection or disclosure upon attorneys who serve as intermediaries or counsel for adoptive parents in direct placement adoptions, they unfortunately cannot be held liable under the Act for failure to disclose information.

Section 7-106(f) permits any individual who is the subject of any information or reports made confidential by the Act to bring an action for damages or equitable relief against anyone who makes or obtains, or is likely to make or obtain, an unauthorized disclosure of the information.

2. Comparison to Liability Created by Common Law Causes of Action

a. Actionable Conduct

Clearly the greatest source of litigation against adoption agencies, and occasionally other professional intermediaries, over the last decade has been suits for failure to disclose health-related information to prospective adoptive parents. Often labeled by both the courts and the media

152. See U.A.A. § 7-105(c).
153. See supra note 141.
as suits for "wrongful adoption," these actions are in fact brought under a variety of legal theories and assert liability for many different types of alleged misconduct related to nondisclosure.\textsuperscript{154}

In 1986, the Ohio Supreme Court, in \textit{Burr v. Board of County Commissioners},\textsuperscript{155} became the first court in a published decision to impose liability upon an adoption intermediary for misconduct related to the disclosure of health information. In the decade since \textit{Burr}, state courts have unanimously imposed liability upon adoption agencies for \textit{intentional} misrepresentation and nondisclosure regarding health-related matters.\textsuperscript{156} One of the most recent cases to extend common law fraud principles to recognize a cause of action for intentional misrepresentation was the decision of a New York appellate court in \textit{Juman v. Louise Wise}.\textsuperscript{157} In \textit{Juman}, the parents alleged that they had been told only that their infant son's birth mother had some emotional difficulty, when in fact she had undergone a frontal lobotomy and a long history of mental illness prior to the child's birth. They further alleged that they would not have adopted their son if they had known the true facts; that their son had a history of psychological disorders, including schizophrenia; and that they have expended very large sums for treatment. The court found these allegations stated a valid claim for fraud, a claim that the court held should be recognized in the adoption setting to advance the state's vital interest in

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\item \textsuperscript{154} \textit{See, e.g.,} D. Marianne Brower Blair, \textit{Getting the Whole Truth and Nothing But the Truth: The Limits of Liability for Wrongful Adoption}, \textit{67 Notre Dame L. Rev.} 851 (1992) (comprehensive examination of the conduct held actionable and the legal theories courts have recognized);
\textit{Adoption Law and Practice}, \textit{supra} note 4, ch. 16.
\item \textsuperscript{155} 491 N.E.2d 1101 (Ohio 1986) (Jury awarded $125,000 in damages to adoptive parents, finding public agency had intentionally misrepresented the mental health history and institutionalization of the birth mother and the medical history of the toddler who was developmentally delayed. The child was ultimately diagnosed with Huntington's Disease).
\item \textsuperscript{156} \textit{See Roe v. Catholic Charities,} 588 N.E.2d 354 (Ill. App. Ct. 1992), \textit{app. den.} 602 N.E.2d 475 (1992) (allegations that agency advised three adoptive families that children were normal in physical and mental condition and development, would require no extraordinary medical care, and that agency had no further background information when in fact agency knew two children had history of psychiatric treatment and all three had exhibited severely abnormal behavior stated a valid cause of action for fraud); \textit{Reidy v. Albany County Dep't of Social Services,} 598 N.Y.S.2d 115 (App. Div. 1993) (failure of agency to reveal history of prior sexual abuse of and by child, despite specific inquiries by prospective adoptive parents prior to placement, coupled with subsequent sexual problems of child following placement that caused psychological harm to child and sibling stated a valid cause of action for fraud); \textit{Gibbs v. Ernst,} 647 A.2d 882 (Pa. 1994) (agencies should be held liable for intentional misrepresentation made to prospective adoptive parents regarding history of physical and sexual abuse).
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adoption and the welfare of its children. During the past decade, state courts have been similarly resolute in recognizing liability when the allegations showed intentional nondisclosure of medical history, even if no affirmative misrepresentation was made. It would appear a similar result would be reached under section 7-105(c), as intentional misrepresentation must clearly be viewed as a violation of the implicit duties required by section 2-106, and intentional nondisclosure is a direct violation of that section, which mandates that all reasonably available medical and social history be provided to the prospective adoptive parents.

Although earlier decisions were split regarding the viability of a claim for negligent misrepresentation of health-related information, recent courts to address this issue have all recognized liability in this context. In 1995, the Massachusetts Supreme Judicial Court, in *Mohr*

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158. 608 N.Y.S.2d at 613-17.
159. Michael J. v. County of Los Angeles, Dep't of Adoptions, 247 Cal. Rptr. 504 (Cal. Ct. App. 1988) (liability may be imposed upon agency if evidence at trial establishes agency intentionally failed to disclose doctor's refusal to render a prognosis for this infant); Roe v. Catholic Charities, 588 N.E.2d 354 (Ill. App. Ct. 1992) (not only affirmative misrepresentations, but intentional failure to disclose necessary medical and psychological information to prospective adoptive parents could subject an agency to liability). *Cf.* M.H. v. Caritas Family Services, 488 N.W.2d at 282 (Minn. 1992) (Plaintiff did not allege sufficient facts to show intentional nondisclosure, when none of evidence showed agency intended to mislead plaintiff by failure to disclose full facts. Agency advised prospective adoptive parents that there was incest in the family, but failed to disclose birth parents were siblings and that father had undergone psychiatric treatment. The Minnesota Supreme Court, however, did not reverse the lower appellate court's finding that intentional nondisclosure could be actionable in the adoption context, as long as there is proof of intent to mislead adoptive parents.); Allen v. Allen, 330 P.2d 151 (Or. 1958) (In a decision that predated *Burr*, the court denied damages for failure to disclose information regarding the child's mental condition, finding evidence failed to support fraud and defendant's conduct was at most careless.).
160. See Gibbs v. Ernst, 647 A.2d at 890-92 (recognizing a claim for negligent misrepresentation if an adoption agency volunteers information to prospective parents, fails to make reasonable efforts to determine whether its representations are true, and misrepresents a material fact about the condition of a child that was foreseeable at the time of placement); Meracle v. Children's Services Society, 437 N.W.2d 532 (Wis. 1989) (Agency could be held liable for negligent affirmative misrepresentation about child's risk of contracting Huntington's disease, if agency voluntarily assumes the duty to inform the parents about the child's risk.); M.H. v. Caritas Family Services, 488 N.W.2d at 288 ("Public policy does not preclude a negligent misrepresentation action against an adoption agency where the agency, having undertaken to disclose information about the child's genetic parents and medical background, negligently withholds information in such a way that the adoptive parents were misled as to the truth."). *Cf.* Wallerstein v. Hosp. Corp. of America, 573 So. 2d 9 (Fla. Ct. App. 1990) (Parents stated valid claim for negligent misrepresentation against physician who assured them infant was healthy when in fact he suffered chronic, fixed nonprogressive encephalopathy and cerebral palsy).

But see Richard P. v. Vista Del Mar Child Care Service, 165 Cal. Rptr. 380 (Cal. Ct. App. 1980) (When adoption agency made full disclosure of medical history, claim
Health Disclosure Provisions

v. Commonwealth,\(^{161}\) upheld a jury verdict against an adoption agency that told adoptive parents that it had no medical history other than the child’s small size and suspected malnutrition, when in fact the agency knew the birth mother was schizophrenic and that the child had been diagnosed as mentally retarded with moderate cerebral atrophy. The court declared that claims based upon both negligent and intentional misrepresentation must be recognized, holding that the "compelling need of adoptive parents for full disclosure of medical background information that may be known to the agency . . . to secure timely and appropriate medical care for the child, but also to make vital personal, health and family decisions . . . outweighs any increased burden that is placed on adoption agencies when liability is imposed for negligent as well as intentional misrepresentation."\(^{162}\) That same summer, the Supreme Court of Rhode Island, in Mallette v. Children’s Friend and Service,\(^{163}\) upheld the validity of a claim for negligent misrepresentation against an agency that was alleged to have revealed only that the birth mother suffered learning disabilities caused solely from head trauma. In fact, she had been diagnosed as mild to moderately retarded with only an undocumented possibility that her condition was caused by trauma; she had been diagnosed as possessing macrocephaly, pseudoepicanthal folds, a high-arched palate, tachycardia, and other symptoms; and the biological grandmother was intellectually limited. At age thirteen the plaintiffs’ son was mentally retarded and severely disturbed.\(^{164}\) The court recognized a claim for negligent misrepresentation despite the fact that Rhode Island had no statutory duty to disclose, declaring that "an adoption system based upon fairness and fuller disclosure of nonidentifying information concerning the child remains the ideal."\(^{165}\) The court went on to state:

[T]he need for accurate disclosure becomes more acute when special needs children are involved. Parents need to be financially and emotionally equipped to provide an atmosphere that is optimally conducive to that special child's growth and development. Although biological parents can assess the risks of having a child by investigating their own genetic backgrounds, adopting parents remain at the mercy of adoption agencies for information, particularly in this state. We believe extending the tort of negligent represen-

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\(^{161}\) 653 N.E.2d 1104 (Mass. 1995).
\(^{162}\) 653 N.E.2d at 1111.
\(^{163}\) 661 A.2d 67 (R.I. 1995).
\(^{164}\) 661 A.2d. at 68.
\(^{165}\) 661 A.2d at 73.
tation to the adoption context will help alleviate some of the artificial uncertainty imposed on a situation inherent with uncertainty.\textsuperscript{166}

Until recently few courts had addressed liability for negligent failure to disclose health-related information apart from liability for negligent affirmative representations. Recently, however, the Pennsylvania Supreme Court, in \textit{Gibbs v. Ernst},\textsuperscript{167} held that "an adoption agency has a duty to disclose fully and accurately to the adoptive parents all relevant non-identifying information in its possession concerning the adoptee,"\textsuperscript{168} and recognized a cause of action for negligent failure to disclose health information separate from liability for negligent misrepresentation. The court found Pennsylvania's disclosure statute created a duty to reveal fully and accurately all available nonidentifying information about a child. Apart from the statute, however, the court found that the unique relationship of trust and confidence between the agency and the prospective parents creates a duty to disclose fully and accurately the history the agency has obtained.\textsuperscript{169}

The plaintiffs in \textit{Gibbs} adopted a child through a private agency that was working in conjunction with a public agency to place a child who was a ward of the state. They were told the child was five (he was actually seven), that he had only been in foster care for two years with only one family, that he had been verbally abused by his mother but not physically or sexually abused, and that he was hyperactive and behind in his school work. Four years after the adoption, the parents learned their son had been severely abused, both physically and sexually, that he had been in ten different foster placements, that his birth mother at one time attempted to cut off his penis, and that he had an extensive history prior to placement of aggressiveness and hostility toward children. By the time they learned this, their son had been permanently institutionalized, after having attempted to amputate the arm of a five year old, attempting to suffocate one cousin, attempting to kill another cousin with a lead pipe, starting a fire which seriously injured another cousin, and deliberately placing Clorox in a cleaning solution, causing his mother severe burns to her hands.\textsuperscript{170} The court found the complaint stated separate valid causes of action for intentional misrepresentation or fraud, negligent misrepresentation, and negligent

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\item \textsuperscript{166} 661 A.2d at 73.
\item \textsuperscript{167} 647 A.2d 882 (Pa. 1994).
\item \textsuperscript{168} 647 A.2d at 892.
\item \textsuperscript{169} 647 A.2d at 892-93.
\item \textsuperscript{170} 647 A.2d at 885-86.
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failure to disclose information that the agencies had in their possession about Michael at the time of the adoption.\textsuperscript{171}

Other courts have also determined that the conduct of negligent failure to disclose could create liability under the legal theories of negligent misrepresentation or negligence.\textsuperscript{172} Several courts, however, often in dicta, have rejected the idea that negligent failure to disclose information, without an affirmative misrepresentation, would create liability.\textsuperscript{173}

The cause of action created by section 7-105(c) would clearly encompass a claim for negligent failure to disclose, since section 2-106 specifically imposes a duty to disclose to prospective adoptive parents all reasonably available information concerning medical and social history. Although the statute does not specifically state that the reports must be accurate, it is quite possible that courts would interpret section 2-106 to create a duty to exercise reasonable care to avoid misrepresentation. Thus, the liability created by section 7-105(c) is clearly consistent with the recent trend of the courts to find liability based on common law negligence theories for negligent failure to disclose and negligent affirmative misrepresentations, but would extend liability if adopted in those

\textsuperscript{171} 647 A.2d at 889-94.

\textsuperscript{172} Roe v. Catholic Charities, 588 N.E.2d 354 (Ill. App. Ct. 1992) (recognizing nondisclosure alone, without affirmative misrepresentation, could create liability under a negligent misrepresentation theory. The court held an adoption agency owes a duty to adoptive parents to give honest and complete responses to adoptive parents' specific requests about the characteristics of a specific child for adoption.); M.H. v. Caritas Family Services, 488 N.W.2d at 288 (negligent withholding of information in a way that misleads adoptive parents can create liability for negligent misrepresentations). See Mohr v. Commonwealth, 653 N.E.2d 1104, 1112 (Mass. 1995) (recognizing liability for negligent misrepresentation, the court went on to state, "We add that an adoption agency does have an affirmative duty to disclose to adoptive parents information about a child that will enable them to make a knowledgeable decision about whether to accept the child for adoption.").

\textsuperscript{173} Michael J. v. County of Los Angeles, Dep't of Adoptions, 247 Cal. Rptr. at 513; Foster v. Bass, 575 So. 2d 967 (Miss. 1990) (The agency failed to fill in a blank on their form next to PKU, causing the pediatrician to erroneously believe the test had been done. The child developed severe and irreversible brain damage which could have been prevented. The court denied liability, holding the agency's actions were not the proximate cause of the child's injuries. The court did not separately analyze duty to transmit information with reasonable care. The opinion could be interpreted as a holding that no such duty existed, or as a determination that the duty was not breached in this case.). See Mallette v. Children's Friend and Service, 661 A.2d 67, 73 (R.I. 1995) ("[T]here is no legislative duty to disclose any information concerning a child's background to potential adopting parents. Although the wisdom of such legislative inaction is certainly open to question, we believe that given the competing policy concerns involved, these issues remain squarely within the Legislature's prerogative). See also Meracle v. Children's Serv. Soc'y, 437 N.W.2d 532, 537 (Wis. 1989).
states whose courts have addressed the issue, albeit often in dicta, and refused recognition of such liability to date.

All courts that have addressed the issue have explicitly rejected the imposition of liability under the common law for failure to investigate. In *Gibbs*, the Pennsylvania Supreme Court refused to allow plaintiffs to proceed to trial on the cause of action for failure to investigate Michael's mental and physical health. The court found that neither common law nor Pennsylvania's adoption statute created a duty of reasonable investigation. Paradoxically, the court found that Pennsylvania's Adoption Act required "a good faith effort to obtain medical history information on the part of adoption intermediaries," but not a "requirement of a comprehensive investigation into the background of a child in order to avoid liability." The court concluded that creation of a duty to investigate would be too burdensome for adoption intermediaries, and that the good faith requirement implicit in the Adoption Act prevents an intermediary from operating on a "less information, less liability" basis. The court did not explain how the Act's requirement of a good faith effort to obtain medical information would be enforced if there is no liability for failure to make reasonable efforts to investigate. It is possible that under the facts as alleged in *Gibbs*, the court may not have felt constrained to recognize the duty to investigate because there were other theories under which plaintiffs could be compensated.

In *Foster v. Bass*, the Mississippi Supreme Court refused to impose liability on an agency that placed a newborn who had not been tested for phenylketonuria. The agency left the space next to PKU blank on the medical history, which the doctor interpreted to mean that the results were not back yet. No test was done and the child suffered severe, irreversible brain damage, which could have been prevented with proper treatment had the test been performed. The parents brought an action on behalf of the child, alleging, among other things, that the agency was negligent for failing to have the infant tested for PKU while he was in their care, and for failing to order the PKU test prior to adoption when their own records failed to record the test results. The majority, however, held that the duty to determine if the child had PKU rested solely with the doctors, and that the agency, which had no physicians on staff, should not be saddled with the same kind of duty to investigate the blank beside PKU on their own form.

174. 647 A.2d at 893-94.
175. 647 A.2d at 894.
176. 575 So. 2d 967.
177. 575 So. 2d at 977.
opinion contained a strong dissent arguing that liability could potentially be premised upon representations made in the agency’s brochure that the agency would “conduct a painstakingly thorough and time consuming investigative procedure” into, *inter alia*, “the child’s physical and mental health potential.”178 Several other courts in dicta have disclaimed a duty to discover health information.179

Thus, the imposition of liability for negligent failure to investigate may be the one issue on which section 7-105(c) makes a significant leap ahead of the common law liability that has been recognized to date. In the Comment to section 7-105(c), the drafters note that

*[t]he Act’s requirement that agencies, parents, lawyers and others involved in an adoption must provide background information that is ‘reasonably available’ is intended to create a statutory duty to use reasonable efforts to obtain the information and to disclose the information that is collected to prospective adoptive parents . . . [S]ubsection (c) allows adoptive parents and adoptees to maintain an action for damages or equitable relief for failures to provide reasonably available background information.*180

Creation of liability for negligent failure to investigate makes eminent good sense. Absent recognition of a duty to investigate, some intermediaries might choose to put little effort into the collection process on the supposition that the less information they possess, the less they are obligated to disclose, and the less their potential liability will be. More commonly, agencies short on staff or time may be tempted to shortcut the process absent liability for such conduct. The concern of the courts that creation of liability for negligent investigation will be unduly burdensome, although well-intentioned, appears to be misplaced. Section 2-106 creates the duty to furnish reasonably available information, which assumes the duty to obtain it. Imposing liability for failure to investigate simply creates incentive to do what the statute already requires. Moreover, the statute provides guidance about the effort expected. The kind of information to be obtained is set out in some detail,181 and sections 2-106 and 3-404(e) instruct that all of the reasonably available information described is to be obtained from any person who has had legal or physical custody of the child, which would always include the birth mother; anyone who has provided medical, psychological, educational, or similar services to the child; and the birth father.182

The law of negligence has long employed a reasonableness standard

178. 575 So. 2d at 987-92.
179. Meracle v. Children’s Serv. Soc’y, 437 N.W.2d at 537; M.H. v. Caritas Family Services, 475 N.W.2d at 98.
181. See *supra* notes 25-49 and accompanying text.
182. See *supra* notes 76-79 and accompanying text.
to determine when conduct is actionable. While it is true that what is reasonable under the circumstances cannot be measured, predicted, and defined with precision in the statute for every circumstance that might arise, imposing a duty of reasonable conduct in the collection of health information is no less onerous than applying the law of negligence to the many other contexts in which it has been employed. If the goals of the UAA regarding the provision of health information are to be realized, adoption intermediaries must make a reasonable effort to collect accurate and complete information. The imposition of liability for failure to fulfill this duty helps ensure that this will occur.

Finally, sections 7-105(c) and 7-106(d) impose liability for making or obtaining an unauthorized disclosure of confidential information. Although suits of this nature have been far less frequent than suits for failure to disclose, it does not appear that establishing a statutory basis for liability against one who made an unauthorized disclosure of confidential adoption information would be a marked expansion of liability under the common law. In 1985, the Oregon Supreme Court, in Humphers v. First Interstate Bank of Oregon, upheld the validity of a claim by a birth mother against the doctor who delivered her child and later assisted the twenty-one year old adoptee in locating her mother by revealing the birth mother’s identity to the daughter. Although the court rejected liability under the theory of invasion of privacy, the court upheld the birth mother’s claim for breach of confidentiality, noting that a number of decisions in other contexts have found that the unauthorized and unprivileged disclosure of confidential information obtained in a confidential relationship can give rise to tort damages. Recently, a federal district court in Pennsylvania upheld an adult adoptee’s claims for invasion of privacy, negligence, and intentional infliction of emotional distress against a caseworker who, without the adoptee’s permission and in violation of state law, released the adoptee’s address to her older biological sister.

The liability under tort law of a person who obtains confidential adoption information does not appear to have been litigated in a pub-

185. See Blair, supra note 21, at 687-95 (discussion of constitutional and tort theories underlying liability for invasion of privacy).
186. John Beauge, Adoptee’s Suit is Permitted to Proceed; Claims Address Illegally Given to Sister, HARRISBURG PATRIOT, May 2, 1996 (suit filed by Carol Sandusky, her spouse and her adoptive parents against Cumberland County Children and Youth Services, its administrator Gary I. Shuey, and caseworker Marlene Bohr in U.S. District Court for the Middle District of Pennsylvania, alleging disclosure violated Pennsylvania law). See also Dinah Wisenberg Brin, Adoptee Battles to Keep Knowledge About Birth Parents, Families Private; She Files Suit After Sister, Caseworker Seeks Her Out, DALLAS MORNING NEWS, Jan. 14, 1996.
lished decision, and the imposition of statutory liability upon this group may well forge new ground.

b. Potential Defendants

Liability for failure to collect or disclose information under the current UAA can only be established against adoption agencies, who have traditionally been the targets of such suits under the common law, and against guardians placing children for adoption. Attorneys who serve as counsel for adoptive parents or adoption intermediaries in direct placement adoption are not currently liable under the Act for failure to investigate or disclose information.

Attorneys representing adoptive parents may well be held liable to the adoptive parents for failure to disclose information under existing tort law, however, under the legal theory of malpractice. Experienced adoption lawyers caution that in a direct placement adoption, failure to obtain a complete health history from both birth parents and provide it to the adoptive parents might be a breach of the attorney’s duty to his clients. Attorneys representing parents who adopt through an agency may have a duty to make reasonable efforts to ascertain whether the health history was investigated and fully conveyed to the clients, to the extent this can be verified by the attorney. One attorney specializing in adoption practice cautions that failure to scrutinize the agency’s written medical report could lead to a malpractice claim. Suits of this nature have already been filed in Texas.

187. See Adoption Law and Practice, supra note 4, at § 16.03[8] (discussion of this theory in the context of wrongful adoption litigation).
188. David Leavitt, Counseling Clients in Independent Adoption 25-26 (California Continuing Education of the Bar 1980); McLeod, supra note 69, at 50 ("A growing trend in recent litigation premised on wrongful adoption... suggests that a careful lawyer should thoroughly disclose the biological parents' available medical background. Lawyers, doctors, and agencies who have failed to disclose or negligently concealed permanent medical history have been held liable. I seek permission from the biological parent to request specific testing during her pregnancy for sexually transmitted diseases (STPs) and AIDS.").
190. In Martin v. Methodist Home, Case No. 90-07815, Complaint at 9 (14th Judicial District, Dist. Ct. of Dallas Cty. Texas), plaintiffs sued the attorney who represented them and the attorney’s firm for malpractice, alleging the attorney failed to insist that the agency fulfill its duty to disclose medical and social history and failed on her own to disclose to the adoptive parents information the attorney allegedly had in her possession. Telephone Interview with Professor Neil Cogan, Counsel for plaintiffs (Apr. 9, 1993). A published opinion resolving a discovery dispute in this case is found in Methodist Home v. Marshall, 830 S.W.2d 220 (Tex. Ct. App. 1992).

In Burgess v. Smithlawn Maternity Center, a similar claim was made by adoptive
Attorneys may also be potentially liable to adoptees who are harmed by the nondisclosure. Although liability for malpractice in favor of third parties has been recognized only in very limited circumstances, a Florida appellate court recently held that a cause of action for professional negligence on behalf of a child against an attorney who initiates a private adoption proceeding does not require privity between the child and the attorney.\(^{191}\) Although the negligence in this case did not involve the disclosure of health-related information, it opens the door for adoptees who were denied proper treatment due to improper disclosure to bring a malpractice action against the attorney who served as intermediary or represented the adoptive parents.

The Act specifically excludes an action for nondisclosure against a birth parent who places a minor for adoption. Comments to section 7-105 note that the exception of birth parents from liability was motivated by a concern that they would otherwise be deterred from consenting or relinquishing. "The Act's goal is to facilitate adoptions, not to impede them by punishing parents."\(^{192}\) Compelled cooperation through a threat of liability would be ineffective and create some risk that parents who were forced to participate would offer inaccurate information. The drafters made a wise decision in this regard.

**VI. Conclusion**

The UAA treats the subject of disclosure of nonidentifying health information in a comprehensive manner. With a few minor modifications and implementing regulations as suggested herein, states should consider adopting these sections, or modifying their existing statutes to include the provisions not currently in their own legislation. The drafters of the UAA created a model that will promote the complete and accurate disclosure of medical and social history to prospective adoptive parents and others with a legitimate interest in the information, thus, facilitating medical care for adoptees and their descendants, the transmission of critical genetic information back to birth families, an opportunity for informed choice by adoptive parents, and an appropriate placement of a child in a home prepared emotionally and financially to meet the child's needs.

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## Appendix A

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Appendix B

Selected UAA Health Disclosure Provisions

SECTION 2-106. DISCLOSURE OF INFORMATION ON BACKGROUND.

(a) As early as practicable before a prospective adoptive parent accepts physical custody of a minor, a person placing the minor for adoption shall furnish to the prospective adoptive parent a written report containing all of the following information reasonably available from any person who has had legal or physical custody of the minor or who has provided medical, psychological, educational, or similar services to the minor:

1. a current medical and psychological history of the minor, including an account of the minor's prenatal care, medical condition at birth, any drug or medication taken by the minor's mother during pregnancy, any subsequent medical, psychological, or psychiatric examination and diagnosis, any physical, sexual, or emotional abuse suffered by the minor, and a record of any immunizations and health care received while in foster or other care;

2. relevant information concerning the medical and psychological history of the minor's genetic parents and relatives, including any known disease or hereditary predisposition to disease, any addiction to drugs or alcohol, the health of the minor's mother during her pregnancy, the health of each parent at the minor's birth; and

3. relevant information concerning the social history of the minor and the minor's parents and relatives, including:
   (i) the minor's enrollment and performance in school, results of educational testing, and any special educational needs;
   (ii) the minor's racial, ethnic, and religious background, tribal affiliation, and a general description of the minor's parents;
   (iii) an account of the minor's past and existing relationship with any individual with whom the minor has regularly lived or visited;
   (iv) the level of educational and vocational achievement of the minor's parents and relatives and any noteworthy accomplishments;

4. information concerning a criminal conviction of a parent for a felony, a judicial order terminating the parental rights of a parent, and a proceeding in which the parent was alleged to have abused, neglected, abandoned, or otherwise mistreated the minor, a sibling of the minor, or the other parent;

5. information concerning a criminal conviction or delinquency adjudication of the minor; and

6. information necessary to determine the minor's eligibility for state or federal benefits, including subsidies for adoption and other financial, medical, or similar assistance.

(b) Before a hearing on a petition for adoption, the person who placed a minor for adoption shall furnish to the prospective adoptive parent a supplemental written report containing information required by subsection (a) which was unavailable before the minor was placed for adoption, but becomes reasonably available to the person after the placement.

(c) The court may request that a respondent in a proceeding under Article 3, Part 5, supply the information required by this section.

(d) A report furnished under this section must indicate who prepared the report and, unless confidentiality has been waived, be edited to exclude the
identity of any individual who furnished information or about whom information is reported.

(e) Information furnished under this section may not be used as evidence in any civil or criminal proceeding against an individual who is the subject of the information.

(f) The Department shall prescribe forms designed to obtain the specific information sought under this section and shall furnish the forms to a person who is authorized to place a minor for adoption or who provides services with respect to placements for adoption.

SECTION 6-103. RELEASE OF NONIDENTIFYING INFORMATION.

(a) An adoptive parent or guardian of an adoptee, an adoptee who has attained 18 years of age, an emancipated adoptee, a deceased adoptee's direct descendant who has attained 18 years of age, or the parent or guardian of a direct descendant who has attained 18 years of age may request the court that granted the adoption or the agency that placed the adoptee for adoption, to furnish the nonidentifying information about the adoptee, the adoptee's former parents, and the adoptee's genetic history that has been retained by the court or agency, including the information required by Section 2-106.

(b) The court or agency shall furnish the individual who makes the request with a detailed summary of any relevant report or information that is included in the sealed records of the court or the confidential records of the agency. The summary must exclude identifying information concerning an individual who has not filed a waiver of confidentiality with the court or agency. The Department or the court shall prescribe forms and a procedure for summarizing any report or information released under this section.

(c) An individual who is denied access to nonidentifying information to which the individual is entitled under this Article or Section 2-106 may petition the court for relief.

(d) If a court receives a certified statement from a physician explaining in detail how a health condition may seriously affect the health of the adoptee or a direct descendant of the adoptee, the court shall make a diligent effort to notify an adoptee who has attained 18 years of age, an adoptive parent of any adoptee who has not attained 18 years of age, or a direct descendant of a deceased adoptee that the nonidentifying information is available and may be requested from the court.

(e) If a court receives a certified statement from a physician explaining in detail why a serious health condition of the adoptee or a direct descendant of the adoptee should be communicated to the adoptee's genetic parent or sibling to enable them to make an informed reproductive decision, the court shall make a diligent effort to notify those individuals that the nonidentifying information is available and may be requested from the court.

(f) If the Registrar receives a request or any additional information from an individual pursuant to this section, the Registrar shall give the individual the name and address of the court or agency having the records, and if the court or agency is in another State, shall assist the individual in locating the court or agency. The Registrar shall prescribe a reasonable procedure for verifying the identity, age, or other relevant characteristics of an individual who request or furnishes information under this section.