

**NOTICE OF FORM CHANGE NO. 03-239**DATE  
12/12/2003**TO:**  
County Welfare Director  
Supply Clerk / Forms Coordinator**FROM:**  
Forms Management Unit  
(916) 657-1907 Community Care Licensing District Offices  
 Private and Public Adoption Agencies District Attorney  
 Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE AD 508 English &amp; Spanish (9/03) - Request For Rescission Of Relinquishment

ORDER UNIT <b>MASTER ONLY</b>	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 9/03	REPLACES 10/99	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input checked="" type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: <b>Department of Social Services Warehouse</b> <b>P.O. Box 980788</b> <b>West Sacramento, CA 95798-0788</b>		<input type="checkbox"/> Other:	

**FORMS DISPOSITION AND SPECIAL INSTRUCTIONS**

DISPOSITION OF OLD SUPPLY <input type="checkbox"/> Use until exhausted	<input checked="" type="checkbox"/> Destroy
USE NEW FORM <input type="checkbox"/> When supply available in DSS Warehouse	<input checked="" type="checkbox"/> Use new form effective <u>9/03</u>
USE FORM IN ACCORDANCE WITH <input type="checkbox"/> All County Letter No. <input type="checkbox"/> Other (specify)	

## ADDITIONAL INFORMATION REGARDING FORM CHANGE

Form is now a Master Only

Check on the internet to see if forms are available at [www.dss.cahwnet.gov](http://www.dss.cahwnet.gov)For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov). Contact Language Services for other languages at (916) 445-6778 or by electronic mail at [LTS@dss.ca.gov](mailto:LTS@dss.ca.gov).

**REQUEST FOR RESCISSION OF RELINQUISHMENT***(for agency use when relinquishment has been filed with and acknowledged by CDSS)***TO AGENCY:**

AGENCY NAME

ADDRESS

TELEPHONE NUMBER

(      )

**TO PARENT:**

Your request to rescind your relinquishment must be confirmed in writing. Complete and sign the below portion of this form and return the entire form to the above agency address within 14 days after you receive it, or by \_\_\_\_\_ . If this form is not returned by the above date, your request for rescission is cancelled.

I, \_\_\_\_\_ mother/father of

(NAME OF PARENT)

\_\_\_\_\_, a minor, relinquished to

(NAME OF CHILD)

\_\_\_\_\_

(NAME OF AGENCY)

now desire to rescind the relinquishment, signed on \_\_\_\_\_ and to restore my

(DATE)

parental rights. I understand that this will not happen unless the agency agrees and completes the bottom portion of this form.

\_\_\_\_\_  
(SIGNATURE OF PARENT)

\_\_\_\_\_  
(DATE)

To be completed by Agency Representative:

The \_\_\_\_\_ agrees with the above-named

(NAME OF AGENCY)

parent to rescind the said relinquishment and to declare it to be of no force and effect.

\_\_\_\_\_  
(NAME OF AGENCY REPRESENTATIVE)

\_\_\_\_\_  
(TITLE)

\_\_\_\_\_  
(SIGNATURE OF AGENCY REPRESENTATIVE)

\_\_\_\_\_  
(DATE)

**(Agency: Return one copy to the California Department of Social Services)**

**PETICION PARA LA ANULACION DE UNA RENUNCIA**

(Para el uso de la oficina/agencia cuando la renuncia se haya presentado al Departamento de Servicios Sociales de California y el Departamento haya dado acuse de recibo.)

**PARA LA OFICINA/AGENCIA:**

NOMBRE DE LA OFICINA/AGENCIA

DIRECCION

NUMERO DE TELEFONO

( )

**AL PADRE/MADRE:**

Su petición para anular su renuncia tiene que ser confirmada por escrito. Complete la siguiente parte de este formulario y devuelva el formulario completo a la dirección de la oficina/agencia que aparece arriba antes de que pasen 14 días, contados a partir de la fecha en que lo reciba, o a más tardar en \_\_\_\_\_. Si este formulario no se devuelve para la fecha señalada, su petición para la anulación se cancelará.

Yo, \_\_\_\_\_, el padre/la madre de

(NOMBRE DEL PADRE/MADRE)

\_\_\_\_\_, un menor, al que renuncié y entregué a

(NOMBRE DEL MENOR)

\_\_\_\_\_,

(NOMBRE DE LA OFICINA/AGENCIA)

ahora deseo anular la renuncia que firmé en \_\_\_\_\_ y recobrar mis derechos como padre/madre.

(FECHA)

Entiendo que esto no ocurrirá a menos que la oficina/agencia esté de acuerdo y complete la parte inferior de este formulario.

(FIRMA DEL PADRE/MADRE)

(FECHA)

(Esta sección es para que sea completada por el representante de la oficina/agencia.)

To be completed by Agency Representative:

The \_\_\_\_\_ agrees with the above-named

(NAME OF AGENCY)

parent to rescind the said relinquishment and to declare it to be of no force and effect.

(NAME OF AGENCY REPRESENTATIVE)

(TITLE)

(SIGNATURE OF AGENCY REPRESENTATIVE)

(DATE)

**(Agency: Return one copy to the California Department of Social Services)**