_______________-__________________ P.N. __________

Please type or print information **WITNESSES**

It is important that we hear from a variety of witnesses who knew both you and your former spouse before and during the marriage. Parents, siblings, and other family members (including former in-laws) are good prospects. Individual and mutual friends are likewise helpful. If you wish to submit additional names, please use a separate sheet of paper, providing the same information.

Name: Mr. / Mrs. / Ms. ______________________________ Relationship To Whom: ____________
Address: ____
Number, Street *City* *State* *Zip*
Telephone Number: __________________

Name: Mr. / Mrs. / Ms. ______________________________ Relationship To Whom: ____________
Address: ____
Number, Street *City* *State* *Zip*
Telephone Number: __________________

Name: Mr. / Mrs. / Ms. ______________________________ Relationship To Whom: ____________
Address: ____
Number, Street *City* *State* *Zip*
Telephone Number: __________________

Name: Mr. / Mrs. / Ms. ______________________________ Relationship To Whom: ____________
Address: ____
Number, Street *City* *State* *Zip*
Telephone Number: __________________

Name: Mr. / Mrs. / Ms. ______________________________ Relationship To Whom: ____________
Address: ____
Number, Street *City* *State* *Zip*
Telephone Number: __________________

Name: Mr. / Mrs. / Ms. ______________________________ Relationship To Whom: ____________
Address: ____
Number, Street *City* *State* *Zip*
Telephone Number: __________________

I have contacted all the witnesses listed above and they have agreed to cooperate.

____
Petitioner Signature

COUNSELING INFORMATION

Have *you* ever received any counseling or psychological treatment?

Yes ☐ No ☐

Has your *former spouse* ever received counseling or psychological treatment? Yes ☐ No ☐

Did *you and your former spouse* receive joint counseling or psychological treatment? Yes ☐ No ☐

If any of the above statements is "Yes" please list the name of the Counselor and/or Agency, complete address, and the dates seen.

NAME	ADDRESS	CITY/STATE	DATES
YOU			
YOUR FORMER SPOUSE			
JOINT COUNSELING			

PLEASE BE SURE TO SIGN THE ENCLOSED RELEASE FORM(S) AND SIGN YOUR NAME AS IT WAS WHEN YOU WERE SEEN BY THE ABOVE COUNSELOR(S).

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information
(Health Care Facility/Counselor's Name)
from the records of _____/_____
(Patient's Name - please print) (Date of Birth)

_____ _____
(Date(s) of treatment)

This information is to be released to **Office of Matrimonial Concerns of the**

Diocese of Erie, 429 E. Grandview Blvd., **Erie, Pennsylvania 16504**
(Name and Address of Requestor)

in order to help me in determining a matter of conscience in reference to my marriage and none of these records will be used for any other purpose or divulged to anyone outside the Marriage Tribunal. The information to be released is:

☐Psychiatric Evaluation ☐Therapy Notes

☐Diagnoses ☐Discharge Summary

☐Other _____

I have been told that, in order to protect the limited confidentiality of these records, my agreement to obtain or release information is necessary and that this consent is limited for the purposes and to the agency or person listed above. This consent will be effective from the date of my signature for a reasonable time in order to effectuate the purposes for which it is given. I also understand that this consent is revocable upon written request except to the extent that action has been taken in reliance thereon. I understand the nature of this release and freely give my consent.

This consent shall be in effect from _____ until _____.

_____ _____
Date of Signature Signature of Patient

_____ _____
Date of Signature Signature of Witness