

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.

Mr.
 Name: Mrs. _____ Relationship _____
 Ms. _____ To Whom: _____
 Address: _____
Number, Street City State Zip
 Telephone Number: _____

Mr.
 Name: Mrs. _____ Relationship _____
 Ms. _____ To Whom: _____
 Address: _____
Number, Street City State Zip
 Telephone Number: _____

Mr.
 Name: Mrs. _____ Relationship _____
 Ms. _____ To Whom: _____
 Address: _____
Number, Street City State Zip
 Telephone Number: _____

Mr.
 Name: Mrs. _____ Relationship _____
 Ms. _____ To Whom: _____
 Address: _____
Number, Street City State Zip
 Telephone Number: _____

Mr.
 Name: Mrs. _____ Relationship _____
 Ms. _____ To Whom: _____
 Address: _____
Number, Street City State Zip
 Telephone Number: _____

Mr.
 Name: Mrs. _____ Relationship _____
 Ms. _____ 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.

| <u>NAME</u> | <u>ADDRESS</u> | <u>CITY/STATE</u> | <u>DATES</u> |
|---------------------------|----------------|-------------------|--------------|
| <u>YOU</u> | | | |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| <u>YOUR FORMER SPOUSE</u> | | | |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| <u>JOINT COUNSELING</u> | | | |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**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, P.O. Box 10397, Erie, Pennsylvania 16514-0397
(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