CATHEDRAL OF
ST. JOSEPH

2305 W. Main Street, Jefferson City, MO 65109 573-635-7991

SACRAMENTAL RECORD REQUEST FORM
AUTHORIZATION FOR RELEASE OF INFORMATION
FROM SACRAMENTAL RECORDS

Request Date:_____

CHURCH IN WHICH SACRAMENT WAS PERFORMED: _____

NAME OF SACRAMENT (check one): ☐ BAPTISM ☐ MARRIAGE OTHER_____

FULL NAME AT TIME OF SACRAMENT: _____

APPROXIMATE DATE OF SACRAMENT: _____

DATE OF BIRTH: _____

FULL NAME OF PARENTS: FATHER _____ MOTHER (include mother's maiden name:) _____

REQUESTOR: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

EMAIL: _____

I agree to hold harmless the Diocese of Jefferson City, the Roman Catholic Church, its Dioceses, Bishops and their successors in office, the aforesaid parish and all other persons connected with them from any liability for releasing this information pursuant to my request. I further authorize St. Joseph Cathedral personnel to access my sacrament records as noted above.

SIGNATURE OF AUTHORIZATION: _____

****A COPY OF PHOTO IDENTIFICATION MUST ACCOMPANY THIS REQUEST****

Note: The person authorizing release must be the person named in the record, the parent of a minor child, or the spouse or adult child if the person is deceased. Anyone else must show proof of power-of-attorney.

Sent via _____ on _____

For Office Use Only

ID Type: _____

Researcher: _____

Revised 7/2022