BETTY McCOLLUM
4TH DISTRICT, MINNESOTA

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UNITED STATES
HOUSE OF REPRESENTATIVES

COMMITTEE ON APPROPRIATIONS

RANKING MEMBER
SUBCOMMITTEE ON DEFENSE

SUBCOMMITTEE ON INTERIOR, ENVIRONMENT
AND RELATED AGENCIES

EX-OFFICIO MEMBER
PERMANENT SELECT COMMITTEE
ON INTELLIGENCE

CO-CHAIR EMERITUS
CONGRESSIONAL NATIVE AMERICAN CAUCUS

Privacy Release Form

The *Privacy Act of 1974* requires written consent from an individual constituent before information can be obtained from a government agency's records. To better serve you, please complete both sides of this form and return it to me. In order to be in compliance with the *Privacy Act of 1974*, this form must be signed. If you are inquiring on behalf of an individual, that individual must complete and sign this form.

Prefix: ☐ **Ms.** ☐ **Mrs.** ☐ **Mr.** ☐ **Mx.** ☐ **Dr.**

Full Name: _____

Address: _____

City: _____ **ZIP Code**: _____

Social Security Number: _____ **Date of Birth**: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

I prefer to be contacted by: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Federal Agencies Involved: _____

Have you contacted other Senate or Congressional offices about this issue? ☐ YES ☐ NO
If yes, who have you contacted?

☐ Senator Klobuchar ☐ Senator Smith ☐ Representative _____

If you wish to designate individuals other than Congresswoman McCollum and her staff, please list them here:

Name: _____ **Phone**: _____

I freely and willingly authorize Congresswoman Betty McCollum and her staff to make inquiries into my personal records and/or files to obtain information about me pertaining to my request for assistance. I understand that I may revoke this authorization at any time.

Signature: _____ **Date**: _____

Please complete other side

Please complete *all* sections that apply to your case

Briefly explain your issue and please state how you would like Congresswoman McCollum to help you.

Please provide a detailed account. Attach or provide any additional relevant correspondence that you have initiated or received concerning this matter.

If your request for assistance involves medical information, please fill out the Authorization to Release Medical Information, under the *Heath Insurance Portability and Accountability Act of 1996 (HIPAA)* and return it along with this form.

Veterans Affairs Issues

Case Number: _____ **Please include a copy of DD214 if relevant**

Department of Defense Issues

Branch: _____ **Unit:** _____

Duty Station: _____ **Rank:** _____

Medicare Issues

I am having problems with: ☐ **Part A** ☐ **Part B** ☐ **Part D** ☐ **Medicare Advantage**

Medicare Number: _____

Social Security Issues

Type of Claim Filed: _____

Has the claim been denied? ☐ **YES** ☐ **NO** **Office you are dealing with:** _____

Immigration Issues

Receipt Number: _____ **Name of Beneficiary:** _____

Alien Number: A-_____ **Date of Birth:** _____ **Place of Birth:** _____

Type of Petition: _____ **Consulate Involved:** _____

Current Immigration Status: _____

Please print and sign this form and return by mail or fax to:

Congresswoman Betty McCollum
661 LaSalle Street Suite 110 Saint Paul, MN 55114 or fax: (651) 224-3056