

BETTY McCOLLUM  
4TH DISTRICT, MINNESOTA

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[www.house.gov/mccollum](http://www.house.gov/mccollum)



UNITED STATES  
HOUSE OF REPRESENTATIVES

COMMITTEE ON APPROPRIATIONS  
RANKING MEMBER,  
SUBCOMMITTEE ON INTERIOR,  
ENVIRONMENT, AND RELATED AGENCIES  
SUBCOMMITTEE ON DEFENSE  
SUBCOMMITTEE ON LEGISLATIVE BRANCH

CONGRESSIONAL  
GLOBAL HEALTH CAUCUS,  
CO-FOUNDER

CONGRESSIONAL  
NATIVE AMERICAN CAUCUS,  
CO-CHAIR

**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.  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 Franken  Senator Klobuchar  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.

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

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**Veterans Affairs Issues**

Case Number: \_\_\_\_\_

Please include a copy of DD214 if relevant

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**Department of Defense Issues**

Branch: \_\_\_\_\_

Unit: \_\_\_\_\_

Duty Station: \_\_\_\_\_

Rank: \_\_\_\_\_

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**Medicare Issues**

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

Medicare Number: \_\_\_\_\_

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**Social Security Issues**

Type of Claim Filed: \_\_\_\_\_

Has the claim been denied?  YES  NO Office you are dealing with: \_\_\_\_\_

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**Immigration Issues**

Receipt Number: \_\_\_\_\_ Name of Beneficiary: \_\_\_\_\_

Alien Number: A- \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Type of Petition: \_\_\_\_\_ Consulate Involved: \_\_\_\_\_

Current Immigration Status: \_\_\_\_\_

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

**Congresswoman Betty McCollum**

165 Western Avenue North, Suite 17, St. Paul, MN 55102 or fax: (651) 224-3056