

BETTY McCOLLUM  
4TH DISTRICT, MINNESOTA

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UNITED STATES  
HOUSE OF REPRESENTATIVES

COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE ON DEFENSE  
SUBCOMMITTEE ON INTERIOR,  
ENVIRONMENT, AND RELATED AGENCIES  
SENIOR DEMOCRATIC WHIP  
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.

**Full Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **ZIP Code:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_ **Evening Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**I prefer to be contacted by:**      Daytime Phone      Evening Phone      Email

**Federal Agencies Involved:** \_\_\_\_\_

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

Senator Franken      Senator Klobuchar      Representative \_\_\_\_\_

I designate the following individual to discuss this matter on my behalf with Congresswoman Betty McCollum and her staff (*if applicable*):

**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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**Veteran's Affairs Issues**

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

Please include a copy of DD214 if relevant

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**Military Issues**

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

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

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

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

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**Medicare Issues**

I am having problems with:

Part A

Part B

Part D

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