

BETTY McCOLLUM  
4TH DISTRICT, MINNESOTA

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www.house.gov/mccollum



UNITED STATES  
HOUSE OF REPRESENTATIVES

COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE ON LABOR, HEALTH AND  
HUMAN SERVICES, EDUCATION  
SUBCOMMITTEE ON LEGISLATIVE BRANCH  
SUBCOMMITTEE ON STATE DEPARTMENT  
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COMMITTEE ON OVERSIGHT AND  
GOVERNMENT REFORM  
SUBCOMMITTEE ON NATIONAL SECURITY  
AND FOREIGN AFFAIRS

SENIOR DEMOCRATIC WHIP

CONGRESSIONAL GLOBAL  
HEALTH CAUCUS, CO-FOUNDER

**Privacy Release Form**

The Privacy Act of 1974 requires written consent from the 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. If you are inquiring on behalf of someone, that person must sign this form.

Mr.  Mrs.  Ms.  Dr.

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

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

**City** \_\_\_\_\_

**ZIP Code** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Home Phone** \_\_\_\_\_

**Work Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_

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

**I prefer to be contacted by:**

Home Phone  Work Phone  Cell 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 Coleman  Senator Klobuchar  Representative \_\_\_\_\_

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

**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**

**Please briefly explain your problem.** In writing, provide a detailed account. Include any additional relevant correspondence that you have initiated or received concerning this matter.

**Please state how you would like Congresswoman McCollum to help you.**

**If your request for assistance involves medical information, please fill out the Authorization to Release Medical Information and return it along with this form.**

**Military or Veteran's Issues**

Rank \_\_\_\_\_ Unit \_\_\_\_\_ Duty Station \_\_\_\_\_

**Medicare Issues**

**I am having problems with:**

Medicare Number \_\_\_\_\_  Part A  Part B  Part D

**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 send it to:**

165 Western Ave. N., Suite 17, Saint Paul, MN 55102 or fax: 651-224-3056

Print Form