

U.S. REPRESENTATIVE GUY RESCHENTHALER

CONGRESS OF THE UNITED STATES

WASHINGTON, D.C. 20515

PRIVACY ACT AND HIPAA AUTHORIZATION FORM

Please Print

Full Name: _____

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

Address: _____

City/State/Zip: _____

Telephone Number: Home _____ **Mobile** _____

Federal Agency Involved: _____ **Email:** _____

Have you contacted any other elected official regarding this case?

Yes/No If so, who? _____

DESCRIPTION OF ASSISTANCE REQUESTED

Please describe the type of assistance you are seeking from the Congressman's office. Include any relevant claim numbers (Tax ID, VA number, Alien Registration, etc.), if any, and attach copies of any related documents or correspondence.

Please use the back of this form for any additional information.

Pursuant to the Privacy Act of 1974 (5 U.S.C. § 552a), and the Health Insurance Portability and Accountability Act of 1996 (110 Stat. 1936; Pub. L. 104-191), I hereby authorize appropriate governmental agencies to release information about me and relevant to this inquiry to the Office of U.S. Representative Guy Reschenthaler.

Signature

Date

Please print this form, complete it and return it to one of my district offices listed at the bottom of my website.