

Privacy Release Form

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| NAME: |  |

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| ADDRESS: |  |

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| --- | --- | --- | --- | --- | --- |
| CITY: |  |  STATE: |  |  ZIP: |  |

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| --- | --- | --- | --- |
| COUNTY: |  |  EMAIL: |  |

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| --- | --- | --- | --- |
| PHONE NUMBERS: Day:  |  |  Other: |  |

|  |  |
| --- | --- |
| MEDICARE BENEFICIARY NUMBER (if applicable):  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SOCIAL SECURITY NUMBER: |  | - |  | - |  |  DATE OF BIRTH: |  | / |  | / |  |

**Check Agency Involved:**

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| --- |
| [ ]  **Social Security** |
| [ ]  **Veterans Administration:** Claim Number: |  |  Branch of Service: |  |
| [ ]  **Immigration:** Alien Number: |  |  Receipt Number: |  |
| [ ]  **IRS:** Tax Years: |  |
| [ ]  **Healthcare:** Insurance Provider: |  |
| [ ]  **Other** (please specify): |  |

Please provide a brief summary explaining your problem/concern. You may also attach **copies** of any relevant documents which may expedite your inquiry (use additional paper if necessary).

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|  | , |

In accordance with the Privacy Act of 1974, I hereby authorize the office of Senator Blackburn to access any relevant information pertaining to my case/claim.

**This authorization is good until such a time as a final decision is made on my case and there is no further administrative appeal available to me.**

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| SIGNATURE: |  |  DATE: |   |