Consent for Release of Personal Records by Executive Agencies

Please complete and return to the following address:
Congressman Geoff Davis
District Office
300 Buttermilk Pike, Suite 314
Ft. Mitchell, KY 41017
(859) 426-0080
(859) 426-0061 (fax)

Name of Agency _____MEDICARE_____

_____
Name of Claimant Date of Birth

_____
Mailing Address

_____
City, State, Zip

_____
Social Security Number Medicare Number

_____
Telephone number for claimant. If none, number where you could be reached.

_____
Name of Medicare Part D provider (Part D only)

Have you contacted any other elected officials about this problem? If yes, who? _____

_____

_____

PLEASE EXPLAIN YOUR PROBLEM AND WHAT YOU WOULD LIKE FOR THIS OFFICE TO DO ON YOUR BEHALF:

_____

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If you wish to authorize the release of information regarding your case to a third party, please provide their names: _____

_____

I have sought assistance from Congressman Geoff Davis on a matter that may require the release of information maintained by your agency, and which you may be prohibited from disseminating under the Privacy Act of 1974.

I hereby authorize you to release all relevant portions of my records or to discuss problems involved in this case with Congressman Geoff Davis or any authorized member of his staff until this matter is resolved. I also affirm that the above information is accurate.

Signature: _____ Date: _____