Authorization to Release Medical Information

If your request for Congressional assistance involves medical information, please fill out the following form to give Congressman Tim Walz's office staff permission to talk to Federal agencies about your medical concerns. Congressman Walz holds your privacy in high regard, and this office will only use the information obtained under this authorization to assist you with your request for Congressional assistance.

Name ____ Date of Birth ______________________

I authorize the disclosure of protected health information indicated below to Congressman Tim Walz and his staff.

I authorize the following United States Government departments, and all agencies and offices therein, including all vendors performing services under contract with the department, agency, or office (herein after "the Agency") to release information about my case to Congressman Tim Walz and his staff.

☐ Department of Health and Human Services

☐ Department of Labor

☐ Social Security Administration

☐ Department of Veterans' Affairs

☐ Other: ____________________________________

I authorize the disclosure of the following types of records:

☐ Billing Information

☐ Correspondence between myself and the Agency

☐ Other: ____________________________________

That cover the following conditions and/or time periods:

☐ Condition(s): _________________________________ ☐ Between: ______________

The purpose of the use of this disclosure is to allow Congressman Tim Walz and his staff to communicate with the Agency about my request for assistance as specified in the accompanying Privacy Release Form (herein after "Casework").

This authorization will automatically expire at the earlier of one year from the date of the signature below, or upon the completion of the Casework, whichever occurs first.

I understand that the medical information released by this authorization may include information concerning treatment of mental illness, alcohol abuse, and drug abuse.

I understand that the authorization for disclosure of this health information is voluntary and that I can refuse to sign this authorization. I understand that I can revoke this authorization at any time by delivering a signed and dated letter addressed to Congressman Tim Walz at 1134 7th St. NW Rochester, Minnesota, 55901. I also understand that this authorization will be placed in my file, and that I will receive a copy after I sign it.
A copy of this authorization with my signature may be utilized with the same effectiveness as an original.

Signature _________________________________ Date _____________________