Congressman Todd Young
9th District, Indiana

Phone: (812) 288-3999
Fax: (812) 288-3873

Consent for Release of Personal Records by Executive Agencies

Please complete and return to the following address:
Congressman Todd Young
District Office
279 Quartermaster Ct.
Jeffersonville, IN 47130

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? _____

_____

_____

(over please)

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9th District, Indiana

Phone: (812) 288-3999
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*PLEASE EXPLAIN YOUR PROBLEM AND WHAT YOU WOULD LIKE FOR THIS OFFICE TO DO ON YOUR BEHALF:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 Todd Young 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 Todd Young or any authorized member of his staff until this matter is resolved. I also affirm that the above information is accurate.

*Signature: _____ Date: _____

*Required Information