



# PRIVACY RELEASE FORM

## OFFICE OF CONGRESSMAN BILL KEATING

The *Privacy Act of 1974 (5 U.S.C. § 552a)* requires that Members of Congress or their staff obtain written authorization before they can acquire information about an individual's case.

NOTE: Members of Congress and their staff cannot order a federal agency to expedite your case or decide a matter in your favor. Our office, however, may be able to help you get a prompt response and resolution.

**Every page of this form must be completed prior to submission to Congressman Keating's office.**

Full Name (  Mr.  Mrs.  Ms.  Dr.) \_\_\_\_\_

Address (street) \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

I prefer to be contacted by:  Home Phone  Cell Phone  Work Phone  Email

**Federal Agencies involved** (✓ all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dept. of Agriculture            | <input type="checkbox"/> Dept. of State          | <input type="checkbox"/> IRS               |
| <input type="checkbox"/> Dept. of Defense                | <input type="checkbox"/> Dept. of Transportation | <input type="checkbox"/> Medicare          |
| <input type="checkbox"/> Dept. of Education              | <input type="checkbox"/> Fannie Mae/Freddie Mac  | <input type="checkbox"/> Social Security   |
| <input type="checkbox"/> Dept. of Justice                | <input type="checkbox"/> HUD                     | <input type="checkbox"/> US Postal Service |
| <input type="checkbox"/> Dept. of Labor                  | <input type="checkbox"/> Immigration             | <input type="checkbox"/> VA                |
| <input type="checkbox"/> Military (specify branch) _____ |  |  |
| <input type="checkbox"/> Other (specify) _____           |  |  |

**Please specify other Senate or Congressional offices you have contacted about this issue:**

Senator(s) \_\_\_\_\_

Representative(s) \_\_\_\_\_

**List other agencies/persons authorized to discuss this matter with Congressman Keating and his staff:** \_\_\_\_\_

*I, the undersigned, acknowledge that I am requesting personal assistance from Congressman Keating and have not signed this form on behalf of another individual. I further acknowledge that all the information I have provided is true and accurate to the best of my knowledge.*

*I authorize Congressman Keating and his staff and agents to obtain my personal records, files and information relating to my request for assistance. I understand that I may revoke this authorization at any time.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name: \_\_\_\_\_



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The following information is required.

**Please briefly explain your problem.** Provide as much detail as possible. Also provide copies of any correspondence or documentation related to this matter.

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**Please state how you would like Congressman Keating to help you.** What is your desired outcome?

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For the following sections, please complete only those issues that apply to your case.

## SOCIAL SECURITY

Type of Issue (√ all that apply)     Disability Claim     Existing Benefits     Back-pay  
 Other (please explain) \_\_\_\_\_

Social Security Office you have worked with: \_\_\_\_\_

Have you filed a Disability Claim?     Yes     No                      Claim Status:     Denied     Appealed

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## MEDICARE

I am having problems with:     Part A     Part B     Part D

Medicare Number \_\_\_\_\_

Other (please explain) \_\_\_\_\_  
\_\_\_\_\_



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## MILITARY PERSONNEL OR VETERAN

Type of issue (√ all that apply)     Active/Military Pay     Military records     GI Bill     VA Claim  
 Other (specify) \_\_\_\_\_  
Status:     Active     Reserve     Retired  
Rank \_\_\_\_\_    Unit \_\_\_\_\_  
Duty Station \_\_\_\_\_

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## IMMIGRATION

Name of Petitioner \_\_\_\_\_  
Date of Birth \_\_\_\_\_    Place of Birth \_\_\_\_\_  
Name of Beneficiary \_\_\_\_\_  
Date of Birth \_\_\_\_\_    Place of Birth \_\_\_\_\_  
Receipt Number \_\_\_\_\_    Alien # A \_\_\_\_\_  
Current Immigration Status \_\_\_\_\_

### **IMMIGRATION FORM FILED:**

G-639     I-131     I-589     I-612     N-400  
 I-90     I-140     I-600     I-730     N-600  
 I-129     I-485     I-600A     I-751  
 I-130     I-526     I-601     I-765  
 Other (specify) \_\_\_\_\_  
 Nonimmigrant Visa (specify type) \_\_\_\_\_

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## INTERNAL REVENUE SERVICE

Personal     Business : Tax ID # \_\_\_\_\_

If this is a business issue, please complete the following:

Business Name \_\_\_\_\_  
Business Address \_\_\_\_\_  
Business Phone \_\_\_\_\_    Business Fax \_\_\_\_\_  
Title \_\_\_\_\_    Signature \_\_\_\_\_

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

If your request for Congressional assistance involves medical information, please fill out this form (hereinafter "the Authorization") to give Congressman Keating's office permission to talk to federal agencies about your medical concerns. The information obtained under the Authorization will only be used for purposes related to your request for Congressional assistance.

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (street) \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

I authorize the disclosure of protected health information indicated below to Congressman William Keating from the 10<sup>th</sup> Congressional District of Massachusetts and his staff and agents (hereinafter together "Congressman Keating").

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 (hereinafter "the Agency") to release information about my case to Congressman Keating.

Department of Health and Human Services       Department of Labor  
 Social Security Administration       Department of Veterans' Affairs  
 Other: \_\_\_\_\_

I authorize 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 \_\_\_\_\_ and \_\_\_\_\_.

The purpose of the Authorization is to allow Congressman Keating to communicate with the Agency about my request for assistance as specified in the accompanying Privacy Release Form (hereinafter "the Casework"). The Authorization will expire upon the completion of the Casework or upon receipt of an authorization revocation letter, as described below, whichever occurs first.

*I acknowledge that the medical information released by the Authorization may include information concerning treatment of mental illness, alcohol abuse and drug abuse, among other ailments. I further acknowledge that a copy of the Authorization will be kept in my file, and another copy will be given to me for my personal files.*

*I understand that the Authorization is voluntary and that I can refuse to sign it. I further understand that I can revoke the Authorization at any time by delivering a signed and dated letter addressed to Congressman William Keating at 1250 Hancock Street, Suite 802N, Quincy MA 02169, 297 North Street, Suite 312, Hyannis, MA 02601 or 2 Court Street, Plymouth, MA 02360.*

**Copied or facsimile signatures herein shall be deemed originals.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name: \_\_\_\_\_



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## OFFICE OF CONGRESSMAN BILL KEATING

Once completed, please sign or initial each page and return to Congressman Keating at:

1250 Hancock Street, Suite 802N  
Quincy, MA 02169  
Phone: 617-770-3700  
Fax: 617-770-2984

OR

2 Court Street  
Plymouth, MA 02360  
Phone: 508-746-9000  
Fax: 508-732-0072

OR

297 North Street, Suite 312  
Hyannis, MA 02601  
Phone: 508-771-0666  
Fax: 508-790-1959

In addition to hearing from Congressman Keating and his office regarding your case, you can also sign-up to receive periodic updates about issues important to you by filling out the section below:

Date: \_\_\_\_\_

Name: \_\_\_\_\_

### Would you like to be on the mailing list for Congressman Keating's eNewsletter?

Yes       No

*Congressman Keating's eNewsletter is a periodic email update that will provide information on important issues and events in our district. You can unsubscribe from this service at any time, and your name and address will never be shared.*

If yes, please provide the email address where you would like to receive the eNewsletter:

\_\_\_\_\_

### Would you like to participate in Bill's next tele-townhall?

Yes       No

If yes, please provide the telephone number where you would like to receive the call:

\_\_\_\_\_

### Which issues concern you most? (√ all that apply)

Economy

Education

Energy

Environment

Fishing

Healthcare

National Security

Transportation

Veterans

Other \_\_\_\_\_