## 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

## Medicare

*Name of Claimant (First, M.I., Last)	*Date of Birth
*Mailing Address	*City, State, Zip
*Social Security Number	*Medicare Number
*Telephone Number	Alternate Telephone Number
Email Address	
Name of Medicare Part D provider (Part	rt D only)
•	nd/relative []website []mail []other elected official
Have you contacted any other elected	ed officials about this problem? If yes, who?

(over please)

## \*PLEASE EXPLAIN YOUR PROBLEM AND WHAT YOU WOULD LIKE FOR THIS OFFICE TO DO ON YOUR BEHALF (please print clearly):

If you wish to authorize the release of information regarding your case to a relative or 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:
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\_\_\_\_\_ Date: \_\_\_\_\_

\*Required Information