PRIVACY RELEASE FORM Please complete this form and return to the following address: Congressman Todd Young 279 Quartermaster Ct. Jeffersonville, IN 47130

*Name of Claiman	nt:			
	(First)	(M.I.)	(Last)	
*Mailing Address	:			
	(Street)			
_	(City)	(State)	(Zip)	
*Home Phone:		Alternate Phone	Alternate Phone:	
*Date of Birth:		Email:	Email:	
How did you hear		d/relative []website []r	mail []other elected official	
HOUSEHOLD II Does claimant hav		ndent children? If so, pl	ease list names and ages:	
	ON NUMBERS:			
VETERAN: Branch of Service Did you retire from	: n the service?	What years did	you serve?	
Date (or approxim	ndy been filed? nate date) claim file	d:	no rvice-Connected Disability nnected Pension	

*Have you heard any response from the Veterans Benefits Administration? If so, please list:

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

(over please) Please attach a copy of any documents that may be helpful to us.

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

*PLEASE EXPLAIN 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 authorize Representative Todd Young, and those acting on his behalf, to obtain information pertaining to this matter in accordance with the Privacy Act of 1974. I also affirm that the above information is accurate.

**SIGNATURE:_____ DATE:_____

*Required Information

**The VA does not recognize Power of Attorney so this line must either be signed by the veteran or completed with an "X" and signed by two witnesses if the veteran is unable to sign.