U.S. SENATOR MARK DAYTON
Bishop Henry Whipple Federal Building
One Federal Drive, Suite 298
Fort Snelling, Minnesota 55111
Phone: (612) 727-5220
Fax: (612) 727-5223
Toll free: (888) 224-9043

PRIVACY ACT RELEASE

I hereby authorize my insurance company(ies), _____ to disclose/release my health information to Senator Mark Dayton's Office staff, for reasons described in this authorization.

Description of private health information to be released:
____ All records, policy information, and claims decisions held or made by the insurance company(ies) listed above.

Person authorizing release:
Name: _____

Address: _____

_____

_____

Phone: _____ Date of Birth: _____

Social Security #: _____ Member ID #: _____

I authorize the persons or entities below to receive the information:
____ United States Senator Mark Dayton's Office and all Health Care Help Line Staff

Please provide the reason for the release of this information:
_____
_____
_____

Date in which this authorization expires:
____ When the above matter is resolved.

Important Information and Agreement of Constituent

(a) My authorization is voluntary.

(b) I understand that I can revoke (terminate) this authorization at any time by notifying the Covered Entity. However, if I do revoke my authorization, it will not apply to any disclosure/release of my health information made prior to the Covered Entity receiving my revocation.

(c) I waive all claims against the Covered Entity for its release of my health information specified in this authorization.

(d) I understand that once my health information is disclosed/released, it is no longer subject to privacy protections given by the Covered Entity if the recipient of the information is not obligated under law to protect the privacy of my health information.

As of today, I hereby authorize the Office of Senator Mark Dayton to access my records and act on my behalf with any and all agencies necessary until the matters listed above are resolved.

_____ _____

(Signature) (Date)

Information

Please provide as much of the following information as you can.

Description of complaint (Please be as specific as possible.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of clinic or doctor: _____

Phone Number of clinic or doctor: _____

Dates of service: _____

Steps or efforts already taken/outcome:

_____

_____

_____

_____

Insurance company's customer service or claims department phone numbers:

Company name:	Phone number:
_____	_____
_____	_____

Names and phone numbers of specific insurance company representatives contacted:

_____	_____
_____	_____

Desired outcome:

_____

_____

_____