Authorization to Release Medical Information

If your request for Congressional assistance involves medical information, please fill out the following form to give my office permission to talk to Federal agencies about your medical concerns. I hold your privacy in high regard, and my office will only use the information obtained under this authorization to assist you with your request for Congressional assistance. Please print and sign this form and send it to: 165 Western Ave. N., Suite 17, Saint Paul, MN 55102 or fax: 651-224-3506.

Name _____ Date of Birth _____

I authorize the disclosure of protected health information indicated below to Congresswoman Betty McCollum and her staff.

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 (herein after "the Agency") to release information about my case to Congresswoman Betty McCollum and her staff.

- ☐ Department of Health and Human Services
- ☐ Department of Labor
- ☐ Social Security Administration
- ☐ Department of Veterans' Affairs
- ☐ Other: _____

I authorize the 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: _____

The purpose of the use of this disclosure is to allow Congresswoman Betty McCollum and her staff to communicate with the Agency about my request for assistance as specified in the accompanying Privacy Release Form (herein after "Casework").

This authorization will automatically expire at the earlier of one year from the date of the signature below, or upon the completion of the Casework, whichever occurs first.

I understand that the medical information released by this authorization may include information concerning treatment of mental illness, alcohol abuse, and drug abuse.

I understand that the authorization for disclosure of this health information is voluntary and that I can refuse to sign this authorization. I understand that I can revoke this authorization at any time by delivering a signed and dated letter addressed to Congresswoman Betty McCollum at 165 Western Ave. N, Suite 17, Saint Paul, Minnesota, 55102.

A copy of this authorization with my signature may be utilized with the same effectiveness as an original.

Signature _____ Date _____

Print Form