**BLAKE FARENTHOLD**
27TH DISTRICT, TEXAS

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WASHINGTON, DC 20515
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COMMITTEES:
TRANSPORTATION AND
INFRASTRUCTURE

OVERSIGHT AND
GOVERNMENT REFORM

JUDICIARY

# Congress of the United States
## House of Representatives
### Washington, DC 20515–4327

## Privacy Release Form

Full Name (First, Middle, Last): _____

Permanent Address: _____

City: _____   State: <u>Texas</u>   Zip Code: _____

Home Phone: _____   Cell Phone: _____

Date Of Birth: _____   Social Security Number: _____

E-Mail: _____

*I authorize the agencies indicated below to release information regarding my file to the office of Congressman Blake Farenthold.*

| | | |
|---|---|---|
| ☐ Dept. of Agriculture | ☐ Dept. of HUD | ☐ Dept. of Veterans Affairs |
| ☐ Dept. of Commerce | ☐ Dept. of Interior | ☐ Nat'l Archives/Records |
| ☐ Dept. of Defense | ☐ Dept. of Justice | ☐ Office of Personnel Mgmt. |
| ☐ Dept. of Education | ☐ Dept. of Labor | ☐ Social Security Admin. |
| ☐ Dept. of Energy | ☐ Dept. of State | ☐ U.S. Postal Service |
| ☐ Dept. of Health/Human Svc. | ☐ Dept. of Transportation | ☐ Other:_____ |
| ☐ Dept. of Homeland Security | ☐ Dept. of the Treasury | _____ |

By signing below, I allow the office of Congressman Blake Farenthold to contact the appropriate agencies, forward my correspondence, discuss the matter, and receive pertinent information from federal agencies. It is my understanding that this form is being used in compliance with the Privacy Act of 1974.

_____   _____
Constituent Signature                        Date

_____   _____
Constituent Liaison                           Date

*Please complete back side of page as well.*

Below, please briefly describe the nature of your concern/request and the steps you have already taken to rectify the matter. Also, describe what you would like the Office of Congressman Farenthold to do, regarding this situation:

_____

_____

_____

_____

_____

_____

_____

_____

I ☐DO ☐DO NOT authorize the office of Congressman Blake Farenthold to release information about my case to Third-Party individuals. *If you indicated "DO", you may list up to 2 authorized contacts (ex. Legal Representative, Spouse, Sibling, Child, Close Friend) below. We will only share information with those listed below if they contact our office. There will be no outgoing contact, under any circumstances, from our staff to Third-Party individuals. At any time, you may provide written notice asking that individuals be removed as authorized contacts on your case.*

Name:_____ Relationship:_____

Name:_____ Relationship:_____

By signing below, you acknowledge that the purpose of our office requiring a copy of your Photo Identification is to verify identity upon completion of this form. You also swear that all information provided to our office, both on this form and verbally, is true and accurate.

_____        _____
Constituent Signature                                          Date

_____        _____
Constituent Liaison                                              Date