PRIVACY RELEASE FORM
OFFICE OF CONGRESSMAN BILL KEATING

The *Privacy Act of 1974 (5 U.S.C. § 552a)* requires that Members of Congress or their staff obtain written authorization before they can acquire information about an individual's case.

NOTE: Members of Congress and their staff cannot order a federal agency to expedite your case or decide a matter in your favor. Our office, however, may be able to help you get a prompt response and resolution.

Every page of this form must be completed prior to submission to Congressman Keating's office.

Full Name (__ Mr. __Mrs. __Ms. __Dr.) _____

Address (street) _____

City _____ Zip Code _____

Social Security # _____ Date of Birth _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

I prefer to be contacted by: ___ Home Phone ___ Cell Phone ___Work Phone ___ Email

Federal Agencies involved (√ all that apply):

__ Dept. of Agriculture	__ Dept. of State	__ IRS
__ Dept. of Defense	__ Dept. of Transportation	__ Medicare
__ Dept. of Education	__ Fannie Mae/Freddie Mac	__ Social Security
__ Dept. of Justice	__ HUD	__ US Postal Service
__ Dept. of Labor	__ Immigration	__ VA

__ Military (specify branch)_____

__ Other (specify)_____

Please specify other Senate or Congressional offices you have contacted about this issue:

Senator(s) _____

Representative(s) _____

List other agencies/persons authorized to discuss this matter with Congressman Keating and his staff: _____

I, the undersigned, acknowledge that I am requesting personal assistance from Congressman Keating and have not signed this form on behalf of another individual. I further acknowledge that all the information I have provided is true and accurate to the best of my knowledge.

I authorize Congressman Keating and his staff and agents to obtain my personal records, files and information relating to my request for assistance. I understand that I may revoke this authorization at any time.

Signature _____ Date _____

Please Print Name: _____

_____ _____
Initials Date

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The following information is required.

Please briefly explain your problem. Provide as much detail as possible. Also provide copies of any correspondence or documentation related to this matter.

_____

_____

_____

_____

_____

_____

Please state how you would like Congressman Keating to help you. What is your desired outcome?

_____

_____

_____

_____

_____

_____

For the following sections, please complete only those issues that apply to your case.

SOCIAL SECURITY

Type of Issue (√ all that apply) ___ Disability Claim ___ Existing Benefits ___Back-pay

___ Other (please explain) _____

Social Security Office you have worked with: _____

Have you filed a Disability Claim? ___ Yes ___ No Claim Status: ___ Denied ___Appealed

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MEDICARE

I am having problems with: ___ Part A ___ Part B ___ Part D

Medicare Number _____

Other (please explain) _____

_____

_____ _____
Initials Date

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MILITARY PERSONNEL OR VETERAN

Type of issue (√ all that apply) ___ Active/Military Pay ___ Military records ___GI Bill ___VA Claim

___ Other (specify) _____

Status: ___ Active ___ Reserve ___ Retired

Rank _____ Unit _____

Duty Station _____

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IMMIGRATION

Name of Petitioner _____

Date of Birth _____ Place of Birth _____

Name of Beneficiary _____

Date of Birth _____ Place of Birth _____

Receipt Number _____ Alien # A _____

Current Immigration Status _____

IMMIGRATION FORM FILED:

___ G-639	___ I-131	___ I-589	___ I-612	___ N-400
___ I-90	___ I-140	___ I-600	___ I-730	___ N-600
___ I-129	___ I-485	___ I-600A	___ I-751	
___ I-130	___ I-526	___ I-601	___ I-765	

___ Other (specify) _____

___ Nonimmigrant Visa (specify type) _____

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INTERNAL REVENUE SERVICE

___ Personal ___ Business : Tax ID # _____

If this is a business issue, please complete the following:

Business Name _____

Business Address _____

Business Phone _____ Business Fax _____

Title _____ Signature _____

_____ _____
Initials Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

If your request for Congressional assistance involves medical information, please fill out this form (hereinafter "the Authorization") to give Congressman Keating's office permission to talk to federal agencies about your medical concerns. The information obtained under the Authorization will only be used for purposes related to your request for Congressional assistance.

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Name _____ Date of Birth _____

Address (street) _____

City _____ Zip Code _____

I authorize the disclosure of protected health information indicated below to Congressman William Keating from the 9th Congressional District of Massachusetts and his staff and agents (hereinafter together "Congressman Keating").

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 (hereinafter "the Agency") to release information about my case to Congressman Keating.

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

I authorize 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 _____ and _____.

The purpose of the Authorization is to allow Congressman Keating to communicate with the Agency about my request for assistance as specified in the accompanying Privacy Release Form (hereinafter "the Casework"). The Authorization will expire upon the completion of the Casework or upon receipt of an authorization revocation letter, as described below, whichever occurs first.

I acknowledge that the medical information released by the Authorization may include information concerning treatment of mental illness, alcohol abuse and drug abuse, among other ailments. I further acknowledge that a copy of the Authorization will be kept in my file, and another copy will be given to me for my personal files.

I understand that the Authorization is voluntary and that I can refuse to sign it. I further understand that I can revoke the Authorization at any time by delivering a signed and dated letter addressed to Congressman William Keating at 2 Court Street, Plymouth, MA 02360, Attn: Michael Jackman.

Copied or facsimile signatures herein shall be deemed originals.

Signature _____ Date _____

Please Print Name: _____

_____ _____
Initials Date

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Once completed, please sign or initial each page and return to Congressman Keating at:

2 Court Street Plymouth, MA 02360 Phone: 508-746-9000 Fax: 508-732-0072	**OR**	297 North Street, Suite 312 Hyannis, MA 02601 Phone: 508-771-0666 Fax: 508-790-1959	**OR**	558 Pleasant Street, Suite 309 New Bedford, MA 02740 Phone: 508-999-6462 Fax: 508-999-6468

In addition to hearing from Congressman Keating and his office regarding your case, you can also sign-up to receive periodic updates about issues important to you by filling out the section below:

Date: _____

Name: _____

Would you like to be on the mailing list for Congressman Keating's eNewsletter?

___ Yes ___ No

Congressman Keating's eNewsletter is a periodic email update that will provide information on important issues and events in our district. You can unsubscribe from this service at any time, and your name and address will never be shared.

If yes, please provide the email address where you would like to receive the eNewsletter:

_____

Would you like to participate in Bill's next tele-townhall?

___ Yes ___ No

If yes, please provide the telephone number where you would like to receive the call:

_____

Which issues concern you most? (√ all that apply)

___ Economy	___ Education
___ Energy	___ Environment
___ Fishing	___ Healthcare
___ National Security	___ Transportation
___ Veterans	___ Other _____

_____ _____
Initials Date