From the Office of

Congressman Michael E. Capuano

7th Congressional District, Massachusetts

Medical Privacy Release

I authorize the staff of Congressman Michael E. Capuano to make inquiries on my behalf. I further authorize my attorney and any and all physicians, medical providers, hospital or insurance personnel and all local, state, federal agencies to discuss my case and/or release my records to the staff of Congressman Capuano.

Print your name (ALL CAPS) ____

Signature ________________________________ Date ______________________

Social Security Number ______________________ Date of Birth _________________

Medicare or Insurance Policy Number _______________________________________

Day time phone number __________________ Home phone number _________________

E-mail address ____

Address ____

City ______________________ State ______________ Zip Code ______________

Please briefly describe the situation/problem and how we could help you. (Continue on back of page if necessary.)

Please mail or fax completed form to:
Office of Congressman Michael E. Capuano
110 First St.
Cambridge, MA 02141
Fax 617-621-8628