PRIVACY ACT AND HIPAA AUTHORIZATION FORM

Please print.

Full name:_____

Social Security Number:_____ **Date of birth:**_____

V.A. Number: _____ **Alien Number:**_____

Place of birth: _____

Current address:

Street/Apt.:_____

City/State/Zip:_____

Home phone:_____ **Work phone:**_____

E-mail address:_____

Federal Agency Involved (if known): _____

Have you contacted any other elected official regarding this case? Yes/No (circle)

If so, who? _____

Pursuant to the Privacy Act of 1974 (5 U.S.C. § 552a), and the Health Insurance Portability and Accountability Act of 1996 (110 Stat. 1936; Pub. L. 104-191), I hereby authorize appropriate governmental agencies to release information about me and relevant to this inquiry to the Office of the 13th Congressional District of Florida. I declare under penalty of perjury that the foregoing is true and correct.

_____ _____

Signature **Date**

Please return the *signed original* form to my District Office at:

Office of the 13th Congressional District of Florida
696 1st Ave N Suite 203
St. Petersburg. FL 33701
727-318-6770
727-623-0619

Constituent's Name (please print):_____

DESCRIPTION OF ASSISTANCE REQUESTED

Please describe the type of assistance you are seeking from the Representative's office (include agency claim numbers, if any, and attach *copies* of any relevant documents and correspondence).

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(*Use the back of this form, if necessary.)*