UNITED STATES CONGRESS ♦ OHIO

Congressman Steve Stivers

CONSENT FOR RELEASE OF INFORMATION

To begin processing your case, please complete the following information. **Please Print:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____ Fax: _____

Social Security Number: _____-_____-_____ Date of Birth (mm/dd/yyyy): _____

OPERS INFORMATION:_____

MEDICARE (Part A, B, D): _____

MEDICAID ISSUE_____

HEALTH INSURANCE ISSUES - Name of Company: _____

INSURANCE I.D. NUMBER:_____

Explain the issue(s) that you are having and your desired outcome as well as the steps you have taken to try to resolve the problem before contacting Congressman Stivers' office. (*Include additional pages if needed or copies of any documentation that you may have which would help expedite your inquiry. Please do not send original documents. If you want your case discussed with a spouse, family member or friend, please give permission and list their name(s) and contact information*). ***Use second page if additional space is required).***

Please Print:

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I am aware that provisions of the Privacy Act of 1974 (Public Law 93-579) prohibits the release of information in my file without my approval. I hereby authorize the above mentioned agency (agencies) to provide information regarding my case or claim to the Office of United States Congressman Steve Stivers.

Signature:_____ Date: _____

Please Return Completed Form and Documents To:

By Mail:
Office of Congressman Stivers
C/O Sherry Stuckert
69 North South St.
Wilmington, OH 45177

By Fax:
Fax: 937-283-7052
Attn: Sherry Stuckert

Questions:
Telephone: 937-283-7049

Constituent Name: _____ (page 2)