PRIVACY RELEASE FORM

____
date

PLEASE RETURN THIS FORM TO:

Senator Mitch McConnell
601 West Broadway, Room 630
Louisville, Kentucky 40202
Fax 502-582-5326

TO WHOM IT MAY CONCERN:

I am aware that the Privacy Act of 1974 prohibits the release of information in my file without my approval.

I authorize the ____________________________________
name of Federal agency or department

to provide information on my claim/case to Senator McConnell or his staff representative designated by him.

This authorization is good until such time as a final decision is made on my case and there is no further administrative appeal available to me.

____
signature

____

____
address

____
telephone number

____
social security number

____
claim number (if any)

____
date of birth

If you wish information provided to parent, child, attorney, or other interested party, please indicate below.

I authorize ____________________________________
to receive information from Senator McConnell or his staff representative designated by him relative to my claim/case.

Signature __________________________