

OFFICE OF U.S. SENATOR BRIAN SCHATZ

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PRIVACY RELEASE: (1) *complete this form*, (2) *sign with a blue or black pen*, and (3) *return to the Honolulu office via mail, fax, or email.*

PERSON 1

(check all that apply)

- ☐ Military Member
- ☐ Dependent/Beneficiary
- ☐ Veteran
- ☐ Taxpayer
- ☐ Federal Retiree
- ☐ Guardian
- ☐ Deceased
- ☐ Other (specify below)

Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____ Date of Birth: _____
First Middle Last

Phone: _____ Email: _____ Date of Death: _____

Address: _____

Social Security or Tax ID #: _____ Civil Service Annuity (CSA or CSF) #: _____

Medicare Beneficiary Identifier (MBI) #: _____ Reference/File #: _____

PERSON 2

(check all that apply)

- ☐ Military Member
- ☐ Dependent/Beneficiary
- ☐ Veteran
- ☐ Taxpayer
- ☐ Federal Retiree
- ☐ Guardian
- ☐ Deceased
- ☐ Other (specify below)

Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____ Date of Birth: _____
First Middle Last

Phone: _____ Email: _____ Date of Death: _____

Address: _____

Social Security or Tax ID #: _____ Civil Service Annuity (CSA or CSF) #: _____

Medicare Beneficiary Identifier (MBI) #: _____ Reference/File #: _____

Relationship of Person 2 to Person 1: ☐ Spouse; ☐ Widow(er); ☐ Son/Daughter; ☐ Parent; ☐ Sibling; ☐ Other: _____

AGENCY AUTHORIZATION: *I authorize the checked agency/agencies to release information about me to Senator Schatz and his staff ("Office").*

- ☐ Department of Defense (DOD); ☐ Department of Veterans Affairs (VA); ☐ Social Security Administration (SSA); ☐ Centers for Medicaid & Medicare (CMS);
- ☐ Internal Revenue Service (IRS); ☐ Office of Personnel Management (OPM); ☐ Department of Education (ED); ☐ Other _____

THIRD PARTY AUTHORIZATION: *I authorize this Office to receive and share information with the following person(s)/office(s) :*

Name: _____ Relationship/Title: _____ Phone: _____ Email: _____

Hawaii Congressional Office(s)/Member(s) you have contacted: Senator Mazie Hirono Congressman Ed Case Congresswoman Jill Tokuda

AUTHORIZATION: *I authorize this Office to make inquiries on my behalf. Pursuant to the Privacy Act I expressly give permission for the agency/agencies identified above to release information about me to this Office to the extent allowed by law. I understand that any information I provide may be shared with federal, state, and county officials. I certify that all information and documents provided are true and complete to the best of my knowledge.*

Signature 1: _____ Date _____ Signature 2: _____ Date _____