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) listed below.*

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

List Hawaii Congressional Office(s)/Member(s) you have contacted:_____

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_____

(Revised Mar 2020)