



SENATOR ROGER MARSHALL, M.D.

www.marshall.senate.gov

Privacy Release Form

Constituents Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

Email Address: _____

Date of Birth: _____

Social Security Number: _____

Please explain your Federal Agency issues/concerns.

Please list what specific action you are seeking from this office.

If you have contacted another office, please list their name below.

(NAME)

Do you currently have an attorney representing you in this regard?

(YES or NO)

I hereby authorize Senator Roger Marshall, M.D. or his staff, under the "Right to Privacy Act, " to request and copy any information regarding this matter from identified agencies. I hereby release you from any liability that may arise by furnishing the requested information.

SIGNATURE: _____

DATE: _____

Please note that our office is not authorized to provide legal advice and/or complete forms on behalf of our Constituents. We cannot guarantee a favorable resolution but will seek the highest level of due diligence to ensure the correct resolution.