



Congressman F. James Sensenbrenner, Jr.
Wisconsin – Fifth District
INQUIRY AND PRIVACY RELEASE FORM



(Please Print)

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ Phone (W): _____

Date of Birth _____ Medicare Number: _____

Name of Agency: _____

For Medicare Advantage or Medicare Part D related matters, please identify

Plan provider: _____ Member ID: _____

DESCRIBE PROBLEM:

Please include copies of relevant information you have.

I hereby authorize the above mentioned agency to release all relevant portions of my records or relevant information in writing or through discussion pertaining to the problems involved, to Congressman F. James Sensenbrenner Jr., or his staff, until the matter has been resolved.

X _____
Signature of Constituent

Please complete and mail or fax this form to:

Congressman Jim Sensenbrenner
120 Bishops Way, Suite 154
Brookfield, WI 53005
Fax (262) 784-9437

Please contact my District Office in Brookfield at (262) 784-1111 or (800) 242-1119 if you have any questions.