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Congresswoman Kim Schrier

Member of Congress
Washington's 8th Congressional District



KIM SCHRIER, M.D.
WASHINGTON'S 8TH DISTRICT



Casework Authorization Form

Full Name:		Date of Birth:	
...on behalf of: <i>(if applicable)</i>		Social Security #	
Relationship <i>(if applicable)</i>		Home Phone:	
E-Mail		Work Phone:	
Mobile Phone:		Fax #:	
Mailing Address		Physical Address <i>(if different)</i>	
City:		State:	
		Zip Code:	
Claim/File #:			
Federal Agency(ies) Involved:			
Constituent Permission			
Please Note: The Privacy Act requires that you authorize access to your private records and authorize this office to release information. Without authorization, an inquiry on your behalf will not be possible			
Desired Resolution:			
Please give a detailed description of your situation with the specific federal agency. <i>(Please feel free to use additional sheets of paper)</i>			
Preferred Communication Method: ☐ E-Mail ☐ Phone ☐			
I hereby request the assistance of the Office of United States Representative Kim Schrier in resolving the matter described in this document and I authorize Schrier and her staff to receive and/or release any information needed to provide assistance.			
Signature(<i>in ink</i>):		Date:	
Please print and fax or mail to our District Office along with copies of any other documentation that you think might be helpful to us when making an inquiry on your behalf. Please understand that you are responsible for all your original documents or copies, and must retain these for your records. We are not permitted to accept gifts for any services you receive. Your signature above is acknowledgement of this policy. We look forward to assisting you. Thank you.			