Print Form

Congressman Doc Hastings
Serving Central Washington

Constituent Assistance Authorization Form

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Daytime Phone: _____ Date of Birth: _____

Social Security #: _____

VA Claim #: _____

Immigrant Registration #: _____

Brief Description of Problem:

_____

_____

_____

_____

_____

_____

_____

This information may also be released to the following person (spouse, parent, attorney, etc.):

_____

Due to the Privacy Act of 1974, Federal and State Government Agencies are prohibited from releasing any information or discussing anything regarding another individual without that individual's written permission. Your signature on this page authorizes me, as your Congressman, to contact the proper officials on your behalf, discuss the matter, and receive any pertinent information.

Signature: _____

Date: _____