

# U.S. HOUSE OF REPRESENTATIVES

## PRIVACY RELEASE FORM - USCIS

Please fill out this form so that the office of Congressman Guest can assist you in the matter you describe below. Pursuant to Public Law 93-579, the Privacy Act of 1974, our office cannot assist individuals without their express written consent.

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Mr.  Mrs.  Ms.  Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*For USCIS cases, please provide us with the following information:*

Alien Registration #: \_\_\_\_\_

USCIS Case/ Receipt #: \_\_\_\_\_

Receipt / Priority Date: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

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In the space provided below please give a brief description of your reason for requesting assistance from Congressman Michael Guest's office. If necessary, please include a separate sheet with additional information. Please attach copies of any supporting evidence.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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I, \_\_\_\_\_, hereby request and authorize the Office of Congressman Michael Guest and his staff to intercede on my behalf with any federal agency relevant to the matter described above, including the right to receive any information contained in my file that he or his staff deems necessary, to forward any pertinent correspondence sent by me/us regarding this matter, or any other action I have pending with any federal agency relevant to the matter described above and therefore, waive all rights in the release of any and all related information and request. *I certify under penalty of perjury that I provided or authorized all the information in the Privacy Release and any documents submitted with it are complete, true and correct.*

*I have not contacted an attorney or any other Congressional office regarding this issue.* I also understand that this inquiry may not conclude in my best interest. I sign this waiver in good conscience and without mental reservation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Additional signature required if information is also in spouse/representative/beneficiary's name or if you want our office to share findings regarding your request with a third party, including family member or friend.)

**WASHINGTON OFFICE:**  
230 Cannon HOB  
Washington, DC 20515  
PHONE: 202-225-5031  
FAX: 202-225-5797

**BRANDON OFFICE:**  
308 B East Government St.  
Brandon, MS 39042  
PHONE: 769-241-6120

**STARKVILLE OFFICE:**  
600 Russell St.  
Suite 160  
Starkville, MS 39759  
PHONE: 662-324-0007  
FAX: 662-324-0033

**MERIDIAN OFFICE:**  
2214 5<sup>th</sup> St.  
Suite 2170  
Meridian, MS 39301  
PHONE: 601-693-6681  
FAX: 601-693-1801