



STATE OF ILLINOIS
OFFICE OF THE LIEUTENANT GOVERNOR

PAT QUINN
LIEUTENANT GOVERNOR

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Place of Work: _____

Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

S.S.#: _____ Email: _____

Alien Registration #: _____

Veteran's Claim #: _____

Branch of Service: _____ Rank: _____

I hereby grant Lieutenant Governor Pat Quinn and his staff permission to obtain and release information necessary to assist me with the following matter:

Signature: _____ **Date:** _____

Please return this form to:
Office of Lieutenant Governor Pat Quinn

**100 W. Randolph, Suite 15-200
Chicago, IL 60601
Fax: 312-814-4862**

**214 State House
Springfield, IL 62706
Fax: 217-524-6262**