AUTHORIZATION FORM

PLEASE RETURN THIS FORM TO THE OFFICE MARKED BELOW. THANK YOU.

DATE: _____ STAFF: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ SSN: _____

GOVT AGENCY: _____ CLAIM NO. _____

I HEREBY AUTHORIZE CONGRESSMAN GOODLATTE OR HIS REPRESENTATIVE TO ACT ON MY BEHALF AND TO HAVE ACCESS TO ANY INFORMATION AND RECORDS PERTAINING TO THIS MATTER.

Sign here_____