# AUTHORIZATION FORM

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

**DATE: _____ STAFF:_____**

**NAME: _____**

**ADDRESS: _____**

**CITY: _____ STATE: _____ ZIP CODE:_____**

**EMAIL ADDRESS: _____**

**TELEPHONE: _____ SSN: _____**

**GOVERNMENT AGENCY: _____**

**CLAIM NUMBER: _____**

***I hereby authorize Congressman Bob Goodlatte or his representative to act on my behalf and to have access to any information and records pertaining to this matter.***

***Sign Here*** **_____**


**Harrisonburg Office**
**70 North Mason St.**
**Harrisonburg, VA 22802**
**540-432-2391 (P)**
**540-432-6593 (F)**

**Lynchburg Office**
**916 Main St.**
**Suite 300**
**Lynchburg, VA 24504**
**434-845-8306 (P)**
**434-845-8245 (F)**

**Roanoke Office**
**10 Franklin Rd., SE**
**Suite 540**
**Roanoke, VA 24011**
**540-857-2672 (P)**
**540-857-2675 (F)**

**Staunton Office**
**117 S. Lewis St.**
**Suite 215**
**Staunton, VA 24401**
**540-885-3861 (P)**
**540-885-3930 (F)**