4-Sight Counseling, Inc.

937 Broadway Suite 305 *573-334-7995*
Cape Girardeau, MO 63701 *573-335-8610 - Fax*

Lender / Bank / Servicer Authorization

Lending Institution:	FAX - Contact Number:
Borrower: Borrower:	Last 4 of SSN: Last 4 of SSN:
Property Address:	Loan Number:

I/we hereby authorize the agent(s) for ***4-Sight Counseling, Inc.*** to speak with our servicer, lender, bank listed above relative to our loan in an attempt for work-out plan for our loan.

I/we hereby expressly authorize ***4-Sight Counseling, Inc.*** its employees, agent/volunteers to disclose any information concerning my financial condistion and status, including but not limited to income, debts, credits, assets and residential and work addresses and phone numbers to creditors unless otherwise required by law, and to obtain whatever relative financial inforatmion from my creditors as ***4-Sight Counseling, Inc.*** to work with the lender for a work-out plan.

This authoization shall remain in effet for the duation of my/our participation in the mitigation program or any other program as offered by ***4-Sight Counseling, Inc.***

I/we hereby agree to hold ***4-Sight Counseling, Inc.*** , its employees, officers, directors and agents harmless from any claim, suit, action or demand made by any of my/our creditors andall other persons, which in any manner may arise from any action or inaction taken by ***4-Sight Counseling, Inc.*** or my/our creditors or any other person, in connection with any service rendered by ***4-Sight Counseling, Inc.*** for me/us.

Client Name:	Client Name:	Date:
Signature:	Signature:	Date:

4-Sight Counseling Agent	Last 4 of EIN	Date
Audrey Franklin Audrey Franklin	4474	
Loretta Kincaid Loretta Kincaid	4474	
Courtney Graber Courtney Graber	4474	