



AUTHORIZATION FOR RELEASE OF INFORMATION

I/we hereby request 4-Sight Counseling of Cape Girardeau, Missouri to develop a budget and financial plan to repay my/our creditors based upon the information provide. I/we agree that all information furnished to 4-Sight is accurate and complete. To determine my/our eligibility to be considered for a Debt Management Plan, I/we authorize 4-Sight counseling to obtain a credit report and to speak to any Creditors. I /we understand that I/we may be disqualified from the 4-sight debt counseling program if I/we did not disclose information on any other credit accounts, with or without a balance.

I/we hereby expressly authorize 4-Sight Counseling, its employees, agent/volunteers to disclose any information concerning my financial condition 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 information from my creditors as 4-Sight Counseling.

This authorization shall remain in effect for the duration of my/our participation in the debt reclamation program or any other program as offered by 4-Sight Counseling.

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

Dated this _____ day of _____, 20 _____

Print Name

Print Name

Social Security Number

Social Security Number

Signature

Signature

Client NO. _____