

RE:

D/A:

Assigned Amount:

Assigned Amount Balance:

PATIENT/MINOR:

COMMENTS:

Please authorize compromise (SETTLEMENT IN FULL) of the above mentioned account as indicated below by signing and returning this authorization.  
Thank you,

559-485-7900

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AUTHORIZATION TO COMPROMISE      ACCT #

This is your written authorization to compromise the above assigned claim in full up to and including the following:

REQUESTED SETTLEMENT AMOUNT:

DISTRIBUTION

PRINCIPAL  
FCB INTEREST  
ATTY FEES  
OTHER FEES

Reason for settlement request:

\_\_\_\_\_  
FIRM NAME

\_\_\_\_\_  
BY

\_\_\_\_\_  
TITLE