

Phone: 860-343-0222  
Fax #: 860-343-1544

## Assignment and Release

I \_\_\_\_\_ hereby authorize Dr. Vajda's office to furnish \_\_\_\_\_ with copies of my records covering his diagnosis, treatment and prognosis and all other information he has, including his charges for services, concerning injuries sustained by me on \_\_\_\_\_.

I also assign directly to Dr. Vajda all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date