Headland
Family
Medicine

NIEL C. RASMUSSEN, M.D.
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Family Medicine

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I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I further authorize and request that insurance payments be made directly to **Headland Family Medicine** should they elect to receive such payment. **This is a direct assignment of my rights and benefits under this policy.** A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by **Headland Family Medicine.** I understand that payment of charges incurred is due at time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by Headland Family Medicine physicians and personnel.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

X_____ _____
Signature fo Patient or Parent if Minor **Date**

Patient Name: **Chart Number:** _____