AUTHORIZATION TO RELEASE INFORMATION:

I, _____, hereby authorize Nabet G. Kasabian, M.D. who has treated or attended me or my dependent to furnish information and/or copies of medical records as may be required by my insurance carrier in order to process payment for said services. I understand that the only information which may be released without my specific written request will relate only to treatment or surgery to myself or my dependent by the physician.

_____	_____	_____
Patient or Guardian	Relation to Patient	Date

AUTHORIZATION TO RELEASE PAYMENT:

I, _____, hereby authorize Nabet G. Kasabian, M.D. who has treated or attended me or my dependent to file claims to and receive payment from my Insurance Carrier(s) for medical or surgical services rendered. I understand that I am responsible for any amount not covered by my insurance.

_____	_____	_____
Patient or Guardian	Relation to Patient	Date

AUTHORIZATION TO PROVIDE MEDICAL TREATMENT:

I, _____, hereby authorize Nabet G. Kasabian, M.D. to provide medical treatment for my dependent child, _____. Additionally, I authorize any required emergency services or treatment that may be determined, by the physician, to be medically necessary.

_____	_____
Patient or Guardian	Date
_____	_____
Witness	Date