**Washington Metropolitan Cardiology**

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**Authorization To Release Medical Information**: I authorize this release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**Authorization To Pay Benefits To Physician:** I hereby authorize Dr. M Rafiq Zaheer and Dr. Swapna Kanuri to apply for benefit on my behalf for covered services rendered by his order. I request that payment from my insurance company be made directly to Dr. M Rafiq Zaheer and/or Dr. Swapna Kanuri (or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I understand, if my balances are not paid timely, I will be responsible for the collection fee and/or attorney fee.

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Printed Name Relationship to Patient

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