

**CARDIOLOGY ASSOCIATES
OF MORRISTOWN**

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I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY
TO PROCESS MY CLAIM.

SIGNED: _____ (PT OR RESPONSIBLE PARTY)

DATE: _____

I AUTHORIZE PAYMENT OF MEDICAL AND SURGICAL BENEFITS TO
Cardiology Associates of Morristown.

SIGNED: _____ (PT OR RESPONSIBLE PARTY)

DATE: _____