Arvind Aggarwal, MD
Harsha Vyas, MD

Authorization to Release Medical Records

I hereby request a copy of my current medical records to be sent to Cancer Center of Middle Georgia, LLC at the below address.

Please include:

1. Most recent dictation ________
2. Pathology reports ___________
3. Most recent labs _____________
4. Radiology reports including a CD if available _____________
5. Other ____

Patient Name: ____

Social Security number: ____

Signature: ____

Date: ____

This authorization will remain valid unless revoked in writing by the patient's Signature.

2400 Bellevue Road, Suite 26, Dublin, GA 31021 PHONE (478) 272-8266 FAX (478) 272-7552 www.ccmgeorgia.com