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MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____ having social security number _____ and a birth date of ___/___/_____, the undersigned, hereby authorize physicians at _____ (hereafter referred to as Third Party) to speak with, provide oral reports to, and to release information from my medical record to Georgia Mountain Ophthalmology, or any of its affiliates (hereafter referred to as GMO). The purpose of this authorization is to allow GMO evaluate my petition for evaluation, rescheduling, or other accommodation. This authorization covers only the information in my Third Party medical record, which is necessary for the limited purpose of evaluating my petition for medical care with GMO.

This authorization shall be valid until cancelled in writing.

Signature: _____ Date: _____

Witness: _____ Date: _____