Georgia Mountain Ophthalmology
150 Interstate South Drive
Suite 200
Jasper, Georgia 30143
telephone 678-454-7329 • *fax* 678-454-7331
www.gmojasper.com

Medical Records Release Authorization

I, _____ having social security number _____ and a birth date of _____/_____/_____, the undersigned, hereby authorize physicians at _____

(Physician's Phone) _____ (Physician's Fax) _____

(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 to evaluate my petition for evaluation, rescheduling, or other accommodation. This authorization covers only the information in my Third Party medical record.

Records requested:

[X] Limited to most recent 12 months for which you have records

This authorization shall be valid until cancelled in writing.

Signature: _____ Date: _____

Witness: _____ Date: _____