**Georgia Mountain Ophthalmology**
150 Interstate South Drive
Suite 200
Jasper, Georgia 30143
*telephone* 678-273-7717 • *fax* 678-465-7600
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] Last date of service plus twelve months prior

This authorization shall be valid until cancelled in writing.

Signature: _____ Date: _____

Witness: _____ Date: _____