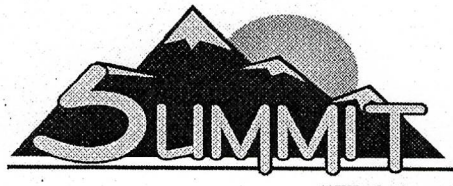

Family Medicine • Laser & Cosmetic Center

"Helping You and Your Family Maintain PEAK Health"

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____To _____From

Summit Family Medicine
Summit Laser & Cosmetic Center
Phone: 336-636-5100
Fax: 336-636-5144

_____To _____From

Name _____
Address _____
_____
Phone _____
Fax _____

I hereby authorize release of medical records for:

Patient Name: _____ Date of Birth: _____

Parent / Guardian Name (If Applicable) _____
Relationship to Patient _____

Purpose of Disclosure:

___ Continued Medical Care
___ Attorney / Legal
___ Social Security / Disability
___ Personal Use
___ Insurance
___ Other

I do hereby authorize any physician or other person who attended, examined, or treated me, or any clinic, hospital, institution, company or federal, state, or municipal agency, office, or bureau, which may have information concerning any medical history, to release to / from Summit Family Medicine or Summit Laser & Cosmetic Center any available information or records concerning my medical history in their knowledge or possession, including (if appropriate) HIV, Communicable Disease, Hepatitis results, etc.

I understand that I may revoke this authorization at any time by sending a notice of revocation in writing to Summit Family Medicine or Summit Laser & Cosmetic Center. I further understand that I may not revoke this authorization to the extent that action has been taken based on this current authorization.

_____ _____
Signature of Patient Date

PAMELA A. PENNER M.D.
515 D West Salisbury St. • Asheboro, NC 27203
Phone: 336.636.5100 • Fax: 336.636.5144