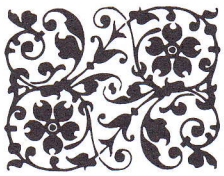

Elizabeth A. Cummins, MD

Obstetrics & Gynecology

Date: _____

You are hereby authorized to give Elizabeth A. Cummins, MD, or her representatives any and all information you may have regarding my condition while under observation or treatment by you, including the history obtained, findings, and diagnosis.

Signed: _____

Printed Name: _____

Date of Birth: _____

Approximate date of treatment: _____

Social Security Number: _____

Records should be sent to:

Elizabeth A. Cummins, MD
50 Lazelle Rd E
Columbus, OH 43235

(614) 888-0800

50 Lazelle Road · Columbus, Ohio 43235 · Fax (614) 888-0858 · Toll Free (877) 888-0802