Medical Record Release Form

Date_______________________________

I am authorizing the release of my complete medical records from:

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Please forward my medical records to:

Michigan Center for Fertility and Women's Health P.L.C.
Dr. Carole Kowalczyk
4700 Thirteen Mile Road
Warren, Michigan 48092
Phone: (586) 576-0431
Fax: (586) 576-0924

By signing this form, I am authorizing the above office to release my complete medical records to Michigan Center for Fertility and Women's Health P.L.C.

Patient Name (Print)____

Signature____

Date of Birth ___________________Social Security Number________________________

I, the spouse of the above patient, request my complete medical records to be released to Michigan Center for Fertility and Women's Health P.L.C.

Name (Print)____

Signature ____

Date of Birth___________________Social Security Number_______________________

Witness Signature____