Michigan Center for Fertility & Women's Health

Medical Record Release Form

Date _____

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

_____
_____
_____
_____

Please forward my medical records to:

Michigan Center for Fertility and Women's Health, PLC

Select one: ____ Dr. Carole Kowalczyk

____ Dr. Nicole Budrys

Select one:

____ 4700 13 Mile Road
Warren, MI 48092
P: 586-576-0431
F: 586-576-0924

____ 4190 Telegraph Road, Ste 1500
Bloomfield Hills, MI 48302
P: 248-203-0900
F: 248-203-0902

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

Patient Name _____

Patient Signature _____

Date of Birth _____

I, the partner of the above name patient, request my complete medical records to be released from Michigan Center for Fertility and Women's Health, PLC.

Partner Name _____

Partner Signature _____

Date of Birth _____

Witness Signature _____