Michigan Center for Fertility
& Women's Health

Medical Record Release Form

Date ____________________

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

Michigan Center for Fertility and Women's Health, PLC
Dr. Carole Kowalczyk or Dr. Nicole Budrys
4700 13 Mile Road – Warren, MI 48092
P: 586-576-0431 – F: 586-576-0924

Please forward my medical records to:

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

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 ____

Reason for Release of Records: ____

***** Please note that all requests require a physician's signature.
Once signed the request can take 10-15 business days***