

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:

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**

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

LAKE ORION
1455 S Lapeer Road #111
Orion Charter Twp, MI 48360
P: 586-576-0431
F: 586-576-0924

rev 04/20

BLOOMFIELD HILLS
4190 Telegraph Rd, Ste 1500
Bloomfield Hills, MI 48302
P: 248-203-0900
F: 248-203-0902

PLYMOUTH
9365 Haggerty Rd
Plymouth, MI 48170
P: 248-203-0900
F: 248-203-0902