

Date _____

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

_____ 4700 13 Mile Road, Warren MI 48092, P: 586-576-0431, F: 586-576-0924
_____ 43494 Woodward Ave., Ste 110, Bloomfield Hills, MI 48302, P: 586-576-0431, F: 248-203-0902
_____ 9365 Haggerty Rd, Plymouth, MI 48170, P: 586-576-0431, F: 734-667-3531

Please forward my medical records to:

PHYSICIAN NAME

ADDRESS

PHONE

FAX

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**