Michigan Center for
Fertility and
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

____ 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

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 _____

WARREN
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Warren, MI 48092
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