Medical Record Release Form

Date_____

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

Michigan Center for Fertility and Women's Health P.L.C.
Dr. Carole Kowalcyzk
4700 13 Mile Road
Warren, Michigan 48092
Phone: (586) 576-0431
Fax: (586) 576-0924

Please forward my medical records to:

_____
_____
_____
_____

By signing this form, I am authorizing the above office to release my complete medical records to the forwarding medical office.

Patient Name (PRINT)_____

Signature_____

Date of Birth_____ Social Security Number_____

I, the spouse of the above patient, request my complete medical records to be released from Michigan Center for Fertility and Women's Health P.L.C.

Name (PRINT)_____

Signature_____

Date of Birth_____ Social Security Number_____

Witness Signature_____

Reason for Release of Records_____

******Please note all requests require doctors signature. Once signed the request can take up to 10 to 15 business days.***

12/13/12