MEDICAL RECORD RELEASE FORM

Date_____

I am authorizing the release of my complete medical record from:
_____

_____

Please forward my medical records to:

Gago Center for Fertility/Gago IVF
Dr. L. April Gago
2250 Genoa Business Park Drive Ste 110/100B
Brighton, MI 48114
Phone 810 227-3232
Fax 810 227-3237

By signing this form, I am authorizing the above office to release my complete medical record to Gago Center for Fertility/Gago IVF.

Patient Name (Print) _____

Signature_____

Date of Birth_____ Social Security Number_____

I, the spouse/partner of the above patient, request my complete medical record to be released to Gago Center for Fertility/Gago IVF.

Name (Print) _____

Signature _____

Date of Birth_____ Social Security Number _____

Witness Signature_____