



LITTLE
MIRACLES
SURROGACY



Little Miracles Surrogacy, LLC.
PO Box 58171
Pittsburgh, PA 15209

MEDICAL RELEASE FORM

Full Name:	
Social Security Number:	
Date of Birth:	
Street Address:	
City:	
State:	
Zip Code:	

I am authorizing the release of my medical records from:

Child First and Last Name:	
Child Date of Birth:	
Birth Hospital:	
Birth Hospital Address:	
Birth Hospital Phone Number:	
Delivery Doctor/OB-GYN Group:	
OB-GYN Office:	
Doctors Name/Group:	
OB-GYN Address:	
OB-GYN Phone:	



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Please forward my medical records to:

Little Miracles Surrogacy, LLC.
Ursula Bresnei
PO BOX 58171
Pittsburgh, PA 15209
Phone: 412-699-2172
Fax: 724-788-4288

CONSENT:

I authorize Little Miracles Surrogacy, LLC. of Pennsylvania, USA to receive any and all medical records pertaining to surrogacy journey.

Signature	Date

Any and all information in this form is the sole property of Little Miracles Surrogacy, LLC of Pennsylvania, USA. Duplication of this form or distribution of any information contained within is prohibited and punishable by law.