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