



## **Patient Authorization for Release of Film and Documents**

I specifically authorize Solis Women's Health to request and obtain the portions of my protected health information described at the bottom of this form for the purpose of continued treatment. However, it is understood that Solis Women's Health will not condition treatment on this authorization. Moreover, I understand my right to inspect or copy the information request and my refusal to sign this authorization.

To afford a document transfer of custody. I would prefer that these documents be mailed "Certified" – return receipt requested. If so transfer, I hereby, release your facility, its owner(s) and employees from legal responsibility for their care. Unless and until I request otherwise, I would prefer that my films and copies of documents be held and maintained in the MSQA regulations. I can be billed at my personal address.

As maintained in the Mammography Qualified Act of 1992 (MSGQA), I hereby request that you forward the following components of my protected health information:

- **All Original mammograms and/or sonograms**
- **Copies of any relevant reports and written documents**

**Please send information to:**

**Solis Women's Health Arlington**  
300 Arbrook - Suite C - Arlington, TX 76014  
Toll Free: 866-717-2551

I have read this authorization and understand what information will be used and disclosed, who may use and disclose this information, and the recipient(s) of that information. If done so in writing.

I fully understand and accept the terms of this authorization.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE FAX BACK IF NO FILMS ARE AVAILABLE.**

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on \_\_\_\_\_

Authorization verified by \_\_\_\_\_ on \_\_\_\_\_