



## REQUEST FOR RELEASE OF FILMS AND REPORTS

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Previous or Maiden Name: \_\_\_\_\_

I hereby authorize Solis Women's Health to release my films and reports to:

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

This is a \_\_\_ Permanent transfer or a \_\_\_ Temporary transfer (Check the area that applies).

Films are to be \_\_\_ mailed or \_\_\_ picked up by \_\_\_\_\_. Check the area that applies. If authorizing another person to pick up films, that person's name is required. **Picture identification is required to obtain films and/or reports.**

I hereby authorize:

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

To release my films and reports to:

Solis Women's Health BenOra Imaging  
1313 E Osborn Rd. Ste 213  
Phoenix, Arizona 85014  
Phone: 602.288.6418 Fax: 602.234.3183

Please notify us if you do not have the requested films.

This is a \_\_\_ Permanent transfer or a \_\_\_ Temporary transfer. Check the area that applies.

Patient

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