



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:

Gree Solis Women's Health on Church Street
1126 N. Church Street Ste. 103
nsboro, North Carolina 27401
Phone: 336.379.0941 Fax: 336.379.7997

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: _____