



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 Women's Imaging & Wellness
5156 Blazer Parkway Ste 120
Dublin, Ohio 43017
Phone: 614.791.9355 Fax: 614.791.2970

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: _____