



**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: \_\_\_\_\_