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, MedTech Mammography Center
1221 E Osborn Road Ste 200
Phoenix, Arizona 85014
Phone: 602.866.0503 Fax: 602.866.0528

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:____________