



**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:

3801 Solis Women's Health on Market Street  
Gree W. Market Street  
nsboro, North Carolina 27407  
Phone: 336.856.8131 Fax: 336.856.7280

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: \_\_\_\_\_