



# Patient Request for Release of Images and Reports

## Solis Mammography Instructions to Patient

Complete this document and send to Solis Mammography by scanning and emailing, or by faxing, to Solis by using the clinic contact details below. We will retrieve your records from your previous facility for you.

Fax: 469-708-4600

Email: SolisMammography@SolisMammo.com

Thank you,

**Solis Mammography Customer Care**

## Patient Instructions to Facility

I, \_\_\_\_\_ (Previous Last Name - if applicable) \_\_\_\_\_

Date of Birth \_\_\_\_\_ hereby authorize:

Name of Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

To release my films and reports to:

Solis Mammography, a department of Medical City Dallas  
7777 Forest Lane, Suite C-236  
Dallas, TX 75230  
Phone: 214-294-9050

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Solis Mammography Instructions to Facility

Our patient has requested the transfer of her films and reports to the Solis Mammography Center above as soon as possible for patient care purposes.

Please notify us immediately if you do not have the requested films and reports.

Thank you,

**Solis Mammography Customer Care**