REQUEST FOR TRANSFER OF IMAGES AND REPORTS

Please complete the form below and fax to 469-708-4600 or email wecare@solismammo.com

Patient Name: _____

Date of Birth:_____ **Telephone Number:**_____

Previous or Maiden Name:_____

Protected Health Information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present, or future health and related health care services. Consistent with our Notice of Privacy Practices, Solis Mammography is required to obtain your authorization to permit the following use or disclosure of your PHI for purposes other than treatment, payment and health care operations. Solis Mammography will not condition its provision of services to you on whether you provide authorization for the requested use or disclosure.

Which location at Solis were you previously seen? _____

Reason for request: _____
Example: Personal use, moving, taking to a physician/surgeon office, going to a new facility

I hereby authorize Solis Mammography to release my:
(please circle one) **IMAGES & REPORTS** or **REPORT(S) ONLY**
Specific Dates of Previous Exam(s) being Requested? If all records, please type ALL _____

Please send to: (choose one of the following)

☐ **Physician/Surgeon**
Full Name of Physician: _____
Address and Phone Number: _____

☐ **Facility/Hospital**
Name of Facility or Hospital: _____
City/State/Zip: _____

☐ **Self**
- ☐ **I would like to be contacted to receive my records electronically.**
  ***Email address required for electronic communication:** _____
- ☐ **I wish to pick up my images from the following Solis location** _____
- ☐ **Please mail my records to (full address)** _____
  _____

Please note, electronic image sharing is available at most Solis locations. You will be contacted if electronic methods are requested. Please keep in mind that communications via email over the internet are not secure. To better protect your privacy, all email communication will be sent in an **encrypted format. You will need to create an account to access the requested information. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Request for records will be fulfilled within 30 days. If you have not been contacted or received records within that timeframe, please contact us at the email address above.*

Patient Signature:_____ **Today's Date:**_____

I understand that I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, or payment, or eligibility for benefits unless: (i) my treatment is related to research and then I will not be permitted to have treatment without signing this Authorization; or (ii) if/when I am receiving health care solely for the purpose of creating PHI for disclosure to a third party on provision of an authorization for the disclosure of the PHI to such third party. I understand that I may inspect or obtain a copy of the PHI of which I am being asked to allow the use or disclosure. I understand that I have the right to revoke this authorization at any time by sending such written notification to Solis Mammography Privacy Official via mail to Solis Mammography, Attn: Privacy Officer, 15601 Dallas Parkway, Suite 300, Addison, Texas 75001. Such a revocation will not be effective to the extent that Solis Mammography has relied on it for the previous use or disclosure of the PHI. If I sign this Authorization, I have a right to receive a signed copy of it. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. This Authorization shall be in force and effective for 1 years from the date of my signature or until I revoke or terminate my authorization in writing, whichever is later, at which time Solis Mammography authorization to use or disclose the PHI specified expires.