REQUEST FOR RELEASE OF IMAGES AND REPORTS

Please fill out 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:_____

Location of prior Solis Exam:

_____

I hereby authorize Solis Mammography to release my films and reports to:

Name of Facility:_____

Address:_____

City, State, Zip:_____

Transfer Type:

____Permanent transfer

____Temporary transfer

(Check the area that applies)

Patient
Signature:_____Date:_____