# 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: WeCare@solismammo.com*

*Thank you,*
***Solis 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 TriStar StoneCrest Medical Center**
537 Stonecrest Dr, Suite 202
Smyrna, TN 37167
Phone: (615) 768-2368

Patient Signature: _____ Date: _____

Patient 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***