REQUEST FOR RELEASE OR TRANSFER OF IMAGES AND REPORTS

Please complete the form below in its entirety and fax to 469-708-4600 or email solismammography@solismammo.com. Complete Option 1 to retrieve patient's prior records from another facility or Option 2 to send Solis' patient's records elsewhere.

Patient Name: _____ **Previous or Maiden Name:** _____

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

Reason for request: ☐ Personal Use ☐ For physician/surgeon office ☐ Transferring to new facility

To release/receive my (check only one): ☐ IMAGES & REPORTS ☐ REPORT(S) ONLY

Specific Dates of Previous Exam(s) being Requested? If all records, please input ALL _____

Option 1. RETRIEVE FROM:

I hereby authorize _____ _____
Name of Facility Address of Facility

_____ _____
Phone Number of Facility Fax Number of Facility

Option 2. RELEASE TO: (choose only one of the following)

☐ **PHYSICIAN/SURGEON OR HOSPITAL/FACILITY**

Full Name of Physician/Facility:_____

Address: _____

Phone Number: _____Fax Number: _____

☐ **Self (Patient Only):**

☐ **EMAIL** to: _____

☐ **PICK UP** from the following Solis location**:**_____

☐ **MAIL TO** (full address):_____

** 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 15 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.