



# 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](mailto: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 River East**  
355 E Grand Ave, Suite 202  
Chicago, IL 60611  
Phone: (866) 717-2551

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**