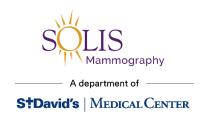
Patient Request for Release of Images and Reports



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: SolisMammography@SolisMammo.com

Thank you,

Solis Customer Care

l,	(Previous Last Name - if applicable)	
	hereby authorize:	
Name of Facility:		
Phone:	Fax:	
Address:		
To release my films and report	s to:	
Solis Mammography,	a department of St. David's Medical Center	
1015 East 32nd St, 3rd Flo	oor, Suite 308	
Austin, TX 78705		
Phone: 512-427-2500		
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