Mammography Record Release Form

Instructions to Patient

Please complete this document and return to us by either:

- **Email:** Mammo-7Hills@axiawh.com
- **Fax:** 513-639-3186
- **Print and Drop Off:** At your Seven Hills care center
- **Mail:**
  Seven Hills Women's Health Centers
  Attn: Mammography Department
  2060 Reading Road, suite 150
  Cincinnati, OH 45202

We will retrieve your records from your previous facility for you.

Patient Instructions to the Facility

First Name: _____ Last Name: _____

Previous Last Name - if applicable: _____ Date of Birth: _____

I Hereby Authorize:

- ☐ Proscan Imaging/Pink Rribbon Center
- ☐ Mercy Anderson Hospital – Women's Center
- ☐ Mercy West Hospital – Women's Center
- ☐ Mercy Jewish Hospital – Women's Center
- ☐ TriHealth – Mary Jo Cropper Family Center for Breast Care (Bethesda North)
- ☐ TriHealth – McCullough-Hyde Memorial Hospital
- ☐ TriHealth - Good Samaritan Breast Center
- ☐ St. Elizabeth Hospital- Breast Center
- ☐ The Christ Hospital – Comprehensive Breast Center
- ☐ Other: _____

Please release my films and reports to PowerShare to SOLIS MAMMOGRAPHY: (select the location your screening mammogram is scheduled)*

☐ Ohio: Anderson Township
7495 State Road, Suite 300
Cincinnati, OH 45255
(Attn: Mammography Department)
PH: (513) 231-3447
Fax: (513) 231-3761

☐ Ohio: Westfork Road
3747 West Fork Road
Cincinnati, OH 45247
(Attn: Mammography Department)
PH: (513) 481-4777
Fax: (513) 389-0473

☐ Kentucky: Turfway
6901 Burlington Pike
Florence, KY 41042
(Attn: Mammography Department)
PH: (859) 282-6700
Fax: (859) 282-6760

Patient Signature: _____

Date: _____ Patient Phone Number: _____

Seven Hills Women's Health Centers Mammography Instructions to Facility

Our patient has requested the transfer of her films and reports to PowerShare to SOLIS MAMMOGRAPHY 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,
Seven Hills Women's Health