



## REQUEST FOR MAMMOGRAMS

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PATIENT PHONE: \_\_\_\_\_

APPROXIMATE DATE OF MAMMOGRAM: \_\_\_\_\_

I authorize: (circle appropriate facility)

Image Care- Vernon

St. Clares – Sussex

Image Care – Sparta

Newton Memorial Hospital

Image Care – Newton

Other Imaging Center: \_\_\_\_\_

To release my mammogram films and breast imaging to a representative of  
Advanced Imaging Associates.

Please allow Advanced Imaging Associates to pick up my mammogram films and  
breast imaging or mail to :

Advanced Imaging Associates

190 Munsonhurst Rd

Franklin, NJ 07416

Any questions, please contact our Mammography department at 973-823-8999.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Appointment Date: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Date form faxed: \_\_\_\_\_

Initial: \_\_\_\_\_