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: ____________