



NASSAU RADIOLOGIC GROUP PC & AFFILIATES

CENTRAL FILM FACILITY

711 STEWART AVENUE, WEST ENTRANCE

GARDEN CITY, NY 11530

TELEPHONE: 516.222.2022, EXTENSION 2006

FAX: 516.284.3860

DATE: _____ NRAD ACCOUNT #: _____

PATIENT: _____

I understand that I am requesting my original films be mailed to me of which there are **NO** additional copies. I will hold NRAD-Nassau Radiologic Group, P.C. harmless for any injury or inconvenience due to the loss or destruction of these films in the mail.

PATIENT'S SIGNATURE: _____

FILMS REQUESTED: _____

There is a \$5.00 postage fee, for your films to be mailed within the state of New York. If films are mailed out-of-state, there is a \$10.00 postage fee. Please be aware we DO NOT mail films to any type of medical facilities.

Method of Payment: Checks are payable to Nassau Radiologic Group, P.C., mail with signed form to the address mentioned above or:

Credit Card: VISA MasterCard American Express

CREDIT CARD #: _____

EXPIRATION DATE _____

CVD CODE (ON BACK OF CREDIT CARD): _____

PHONE NUMBER: _____

MAILING ADDRESS:

THIS IS MY PERMANENT ADDRESS