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**CENTRAL FILM FACILITY**  
711 STEWART AVENUE, WEST ENTRANCE  
GARDEN CITY, NY 11530  
TELEPHONE: 516.222.2022, EXTENSION 2006  
FAX: 516.284.3860

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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 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, mailed 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