



# REQUEST FOR FILM RELEASE

## MONTCLAIR BREAST CENTER REQUEST FOR FILM RELEASE

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ hereby give permission for \_\_\_\_\_  
Name of Facility and Address

\_\_\_\_\_

to release my previous mammogram films and reports to Montclair Breast Center.

### PLEASE MAIL THEM TO:

**Montclair Breast Center  
37 North Fullerton Ave  
Montclair, NJ 07042**

Please ensure that my request is completed before \_\_\_\_\_.

Thank you in advance for your assistance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date