

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____ Date of Birth: ____/____/____

I HEREBY AUTHORIZE REAL TIME LABORATORIES TO RELEASE MEDICAL INFORMATION CONCERNING
MYSELF TO:

Name (Person, Employer, Insurance, Worker's Compensation, Physician, Hospital, Or Other)

Address

City State Zip Code

Fax No. Telephone No.

Patient's Signature Authorizing Release

Printed Name

_____/_____/_____
Date:

This ***Release of Information*** is a onetime release.

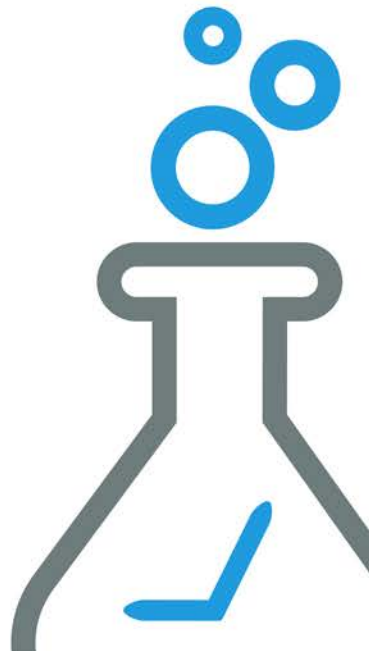
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