REALTIME LABORATORIES INC.
Cutting edge. Breaking barriers.

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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F 972.243.7759

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