REALTIME LABORATORIES INC.
Cutting edge. Breaking barriers.

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

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

_____
Address

_____
City State Zip Code

_____
Fax No. Telephone No.

_____
Email

I, _____, Parent or Legal Guardian of _____, a minor child/dependent, hereby authorize lab results to be released to:

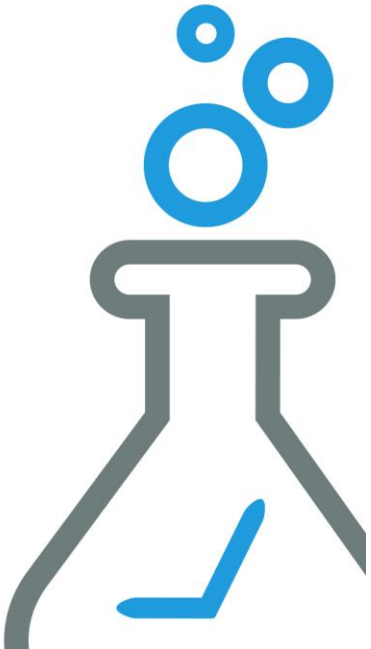
_____ _____
Signature Authorizing Release Printed Name

_____/_____/_____
Date:

*This Release of Information is valid:* ***Until December 31st, 2017***

***Email back to clientservices@realtimelab.com***

***FAX: 972-492-0729***



P 972.492.0419
F 972.243.7759

4100 Fairway Court, Suite 600
Carrollton, TX 75010

CAP #7210193 CLIA #: 45D1051736