REALTIME LABORATORIES INC.
Cutting edge. Breaking barriers.

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

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

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

_____
Address

_____
City State Zip Code

_____
Fax No. Telephone No.

_____
Email

_____ _____
Signature Authorizing Release Printed Name

_____/_____/_____
Date:

This Release of Information is valid: ***Until December 31st, 2018***

Email back to clientservices@realtimelab.com

FAX: 972-492-0729

RTL Form: 10.7.ZZZ
Revised : May 17, 2017

V3 - 2-21-2017

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