Domenica Rubino, M.D.
Washington Center for Weight Management & Research, Inc.
2800 S. Shirlington Road, Suite 505, Arlington, VA 22206
Office #: 703.807.0037 Fax #: 703.807.0038

AUTHORIZATION RECORDS RELEASE FORM

DATE: ______________________

DOCTOR'S NAME: ____

ADDRESS: ____

____

OFFICE NUMBER: _______________ FAX NUMBER: _______________

I hereby authorize and request for you to release the following medical records to
Dr. Domenica Rubino at the above address.

____ Most recent progress notes from my last visit ____ Last EKG completed

____ Most recent physical exam results ____ Most recent blood work results

____ Other:____

Thank you,

____
(Printed Name) (Date of Birth)

____
(Signature)

____
(Street Address)

____
(City, State, Zip)

____
(Contact Phone Number)