Domenica M. Rubino, MD
Washington Center for Weight Management & Research
2800 S. Shirlington Road, Suite 505
Arlington, VA 22206
703-807-0037 (phone)
703-807-0038 (fax)

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)