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Medical Release Form

Patient Full Name _____

D.O.B. _____

I, the undersigned, authorize the release of

Any and all medical records
The following reports:

From: (physicians name and address)

To be forwarded to:

Vicki Kobliner MS RD
Victoria Kobliner RD LLC
150 Danbury Road
Wilton, CT 06897
203

Signature Date

Print Name