Ivette Valle, M.D.
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Tel: (305) 818-5637
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REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Date/Fecha: _____
Patient Name / Nombre: _____
Patient Date of Birth / Fecha de Nacimiento:_____
SS# / Seguro Social: _____|

Release Records From: _____
_____
_____

Release Records To:

Ivette Valle MD PA
1435 W. 49th Place, Suite 400-A
Hialeah, FL 33012
Telf: 305-818-5637
Fax: 305-818-5639

SIGNATURE / FIRMA:

_____

Relationship to Patient: Relacion con el Paciente:

_____

A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.

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