

# MORGAN & MORGAN

November 10, 2022



11785192

Winter Park Integrity Medical Group, LLC  
1801 Lee Road, Suite 304  
Winter Park, FL 32789-2101

Re:      Our Client:              Donhav Noname  
         Date of Accident:        4/22/2021  
         Date of Birth:              11/7/1990

Dear Sir or Madam:

As you are aware, our firm represents the above individual for injuries he or she sustained in the referenced accident.

Our records indicate there may be an outstanding balance with your office for treatment that was rendered in connection with this accident. Please indicate on the attached form what balance, if any, is outstanding at this time.

Also, please provide our office with a complete itemized list of services and charges.

Please respond to this letter listing any outstanding balances within ten (10) days. Verbal responses to this request will not be accepted. All account balances must be in writing.

Thank you for your prompt attention to this matter. Should you have any questions please do not hesitate to contact me directly at (901) 333-1823 or pblair@forthepeople.com. You can fax your reply to me directly at (901) 524-1787.

Sincerely,

*Preston Blair*

Preston Blair

pb/pb

**PATIENT ACCOUNT BALANCE**

Name of Patient: Donhav Noname (11785192)

Account Number: \_\_\_\_\_

Patient Account Balance: \_\_\_\_\_

**PLEASE ATTACH AN ITEMIZED BILL  
SHOWING ANY/ALL UNPAID CHARGES**

Total Charges Billed: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Paid by No Fault Insurance: \_\_\_\_\_

PIP Fee Schedule Adjustments: \_\_\_\_\_

Paid by Medicare or Medicaid: \_\_\_\_\_

Paid by Health Insurance: \_\_\_\_\_

Paid by Patient: \_\_\_\_\_

Adjustment(s): \_\_\_\_\_

Account balance for Morgan and Morgan, P.A.  
(For Legal Conferences, Depositions, Reports, etc.): \_\_\_\_\_

Doctor/Firm Name:      Winter Park Integrity Medical Group, LLC

Signed by: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Date: \_\_\_\_\_

# **Morgan & Morgan Fort Myers PLLC**

## **AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

### **\*\*Records Requested in Electronic Format per 45 CFR 164.524(c)(2)(ii)\*\***

1. The undersigned patient, named below, hereby executes this authorization in compliance with the Federal Health Insurance Portability and Accountability Act, HIPAA, 45 CFR 164.104, 45 CFR 164.508 and 45 CFR 164.524.

2. This authorization is directed to the following healthcare provider (including its agents, employees and associates):

Winter Park Integrity Medical Group, LLC  
1801 Lee Road, Suite 304  
Winter Park, FL 32789-2101

3. The above-named healthcare provider is requested to release the protected health information (PHI) that is described below, to the patient's attorney:

Morgan & Morgan Fort Myers PLLC  
703 Waterford Way, Ste. 1000  
Miami, FL 33126  
Telephone: (305) 929-1900 – Fax: (305) 929-1924  
Attn: Preston Blair, Esquire  
Email address: pblair@forthepeople.com

4. The protected health information released herein is specifically as follows:

All medical information of any nature whatsoever, from any source whatsoever, which is maintained by you in your records regarding the referenced patient and which is requested by my attorneys. If you are a physician or out-patient clinic, you are authorized to send your entire chart upon their request, including not only the records dictated or written up by you, but also insurance records, handwritten notes, telephone memoranda, outside records, correspondence, or any other tangible item maintained in my chart.

If you are a hospital, you are authorized to release my complete records including x-rays or similar studies, office notes, face sheets, discharge summaries, history and physical, consultation notes, intra-operative records, anesthesia records, operative reports, recovery room, pathology reports, medication administration records, EKG reports, EKG strips, EEG reports, EEG strips, therapy notes, orders, progress notes, laboratory results, nurses notes, vital sign sheets, intake/output records, reports of all x-rays, mammograms, CT scans, MRIs or PET scans, emergency room records, transfer records, operative reports, anesthesia records, admitting summary, discharge summary, discharge instructions, personal property list, in-patient records, out-patient records, clinic records, correspondence, photographs, videotapes, telephone messages, computer generated information, medical bills, pharmacy and drug records, health insurance forms, insurance claim forms, insurance payment forms, Medicaid or Medicare records concerning any medical treatment that I have received from you, at your institution, or which you keep in the regular course of business. I hereby authorize release of all records regarding mental health, psychiatric, chemical dependency or HIV. A photo static copy of this authorization shall be as valid as the original.

**IN ACCORDANCE WITH THE PROVISIONS OF 45 CFR §164.524(C)(3)(II), I SPECIFICALLY REQUEST THAT COPIES OF MY MEDICAL RECORDS BE TRANSMITTED TO MY ATTORNEY IDENTIFIED IN PARAGRAPH 3 ABOVE, AS MY DESIGNEE, AND MAILED TO THE ADDRESS SHOWN IN THAT PARAGRAPH, AND THAT THE RECORDS BE PROVIDED IN ELECTRONIC FORMAT (PDF FORMAT ON CD MEDIA), AS REQUIRED BY 45 CFR §164.524(C)(2)(II).**

*Note: a COPY of this Authorization Shall Be Treated as an Original*