FAX

Date:	10/17/2023
Pages including cover sheet:	5

To:	13038655666@rcfax.com
Phone	
Fax Phone	*(303) 865-5666*

From:	Sandra Picone
	Quick Med Claims
	17806 IH 10 W STE 320
	San Antonio
	TX 78257
Phone	(877) 830-7928 * 306
Fax Phone	12107873707

NOTE:

media.pdf

MEMORANDUM

Re: Record Requests

Dear Law Firm,

We will now be fulfilling billing records, medical records, balance verifications and reduction requests via ChartSwap, www.ChartSwap.com .

ChartSwap is a HIPAA compliant platform launched to facilitate electronic medical and billing record exchange between medical providers and law firms, and other requesting parties. It's free to register and requestors can use ChartSwap to request, track, pay for and download records.

Requests via mail or fax or email are no longer processed, please re-submit this request via ChartSwap.com using the following steps.

1. Register at http://www.chartswap.com/register as a Record Requestor
2. Sign in and Search for a Provider, Enter Request Details, then Upload Supporting Documents
3. Once your request has been reviewed and records are available, you will receive a notification and invoice which you can pay with a check or credit or debit card.

Please contact ChartSwap directly at 855-879-7927 if your firm needs to register more than one user or if you would like to schedule training for your employees.

FAX

Date:	10/16/2023
Pages including cover sheet:	3

To:	8558105021@rcfax.com
Phone	
Fax Phone	*(855) 810-5021*

From:	Michel Estrada
	The Ramos Injury Firm
	10190 Bannock St., Ste. 200
	Northglenn
	CO 80260
Phone	(888) 418-9896 * 4373
Fax Phone	13038655666

NOTE:

ATTN: BILLING DEPT

RAMOS LAW
INJURY DIVISION

October 16, 2023

Sent via facsimile: 855-810-5021

Platte Valley Ambulance Service
P.O. Box 90
Danville, PA 178210090

RE: Medical Bills for Theodore James Angel
Date of Birth: September 15, 1975
Injury Date: February 23, 2023
Run No.: 23-22603

Billing Representative:

I am writing in regard to the medical bills owed by Theodore James Angel to Platte Valley Ambulance Service for the medical care incurred as a result of the February 23, 2023 incident.

Please indicate the balance amount in dollars for dates of service 02/23/2023 to present and sign this letter below. Please return fax back to our office at 303-865-5666 confirming the current balance related to this incident.

Final Balance $_____

Signed By: _____ Date: _____

Thank you once again for assisting.

Sincerely,

RAMOS LAW

Michel Estrada
Paralegal

/me

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Platte Valley Ambulance **to release medical information from the records of:**

(Name of Facility)

Patient Name: Theodore James Angel **D.O.B.** September 15, 1975 **SS#** 523-21-6442

Patient Street Address: 6002 Grape Dr Commerce City CO 80022

Date(s) of Treatment Requested: 2/23/2023

Information to be disclosed (check all applicable items to be released):

☐Discharge Summary	☐ER Record	☐Progress Notes	☐Treatment Plans
☐Discharge Instructions	☐X-Rays Reports	☐Medication Records	☐Commitment Papers
☐History and Physical	☐Lab Reports	☐Doctor's Orders	☐HIV Testing
☐Consultations	☐EKG/ECG Tests	☐Nurse's Notes	
☐Operative Report	☐Therapy Notes		

☒Other (please specify): Balance

Purpose Or Need For the Disclosure Is:

☐Continued Medical Care ☐Insurance XLegal ☐Patient's Own Use ☐Other _____

The Information May Be Disclosed To:

Ramos Law
10190 Bannock St., Suite 200
Northglenn, CO 80260
PH: (303) 733-6353
FX: (303) 865-5666

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, and enrollment in a health plan or my eligibility for health care benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

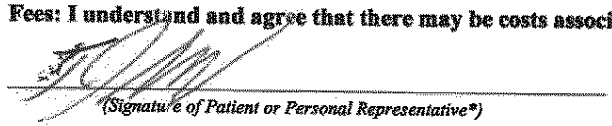
This authorization expires on: _____ **or upon the following event:** CASE SETTLEMENT

(Date)

(If no date is specified, this authorization will expire in six months from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.



(Signature of Patient or Personal Representative)*

10/16/2023

(Date of Signature)

*** If signed by a personal representative, a description of the representative's authority to act is as follows:**