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.

_____ 10/16/2023
(Signature of Patient or Personal Representative)* *(Date of Signature)*

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