

February 14, 2024

ATTN: SUBROGATION  
Cigna  
*By fax – 877 815 4827*

My Client:	Tamara Catherine Anderson
Date of Loss:	February 5, 2024
Date of Birth:	August 14, 1996
SS #:	651-01-4405

To Whom It May Concern:

This office represents the interests of Tamara Catherine Anderson, who was injured in an accident on February 5, 2024.

Our office is requesting a current ledger showing all bills received and all payments made related to the February 5, 2024 incident.

If you have any questions or need additional information, please call our office or email [AOaks@ramoslaw.com](mailto:AOaks@ramoslaw.com).

Sincerely,

RAMOS LAW

Alicia M. Oaks  
719.600.5413  
[AOaks@ramoslaw.com](mailto:AOaks@ramoslaw.com)  
Attorney

/JJE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Cigna to  
release medical information from the records of:  
(Name of Facility)

Patient Name: Tamara Catherine Anderson D.O.B. August 14, 1996  
SS# 651-01-4405

Patient Street Address: 6730 Tullamore Dr, City: Colorado Springs  
State: CO Zip Code: 80923

Date(s) of Treatment Requested: 2/5/2024 - To present

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): Subro/ledger/EOB

Purpose Or Need For the Disclosure Is:

- ☐ Continued Medical Care
- ☐ Insurance
- ☒ Legal
- ☐ 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.

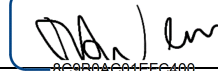
I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

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.

80980A001EFC408



(Signature of Patient or Personal Representative\*)

02.14.2024  
(Date of Signature)

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

- ☐ Parent
- ☐ Legal Guardian
- ☐ Health Care Power of Attorney
- ☐ Administrator
- ☐ Executor of Estate
- ☐ Next of Kin
- ☐ Beneficiary