RAMOS LAW
INJURY DIVISION

April 26, 2024

**SENT VIA FAX: 866-741-4989**
Sky Ridge Medical Center
10101 Ridgegate Pkwy
Lone Tree, CO 80124

| | |
|---|---|
| **Our Client:** | **Tamara Anderson** |
| **Date of Birth:** | **August 14, 1996** |
| **Injury Date:** | **February 05, 2024** |
| **Account No:** | **1512407063** |

To Whom It May Concern:

I am requesting written confirmation of the outstanding balance for my client, Tamara Anderson, for treatment received by your facility on February 05, 2024. Please provide the total charge amount, total client payments, total insurance payments, and adjustments made for Date of Service 02/05/2024. Please return by fax to our office at 303-865-5666, or email directly to myself confirming the current balance related to this incident

Sincerely,

RAMOS LAW

*Simonique Moss*
Simonique Moss
Paralegal
SMoss@ramoslaw.com

Total balance due for incident on February 05, 2024:_____

Health Insurance Paid: _____ Health Insurance Adjustments: _____

Client Payments: _____Outstanding Balance: _____

Total Sent to Collections & Collections Contact: _____

Signed By: _____ Date: _____

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**I hereby authorize** Sky Ridge Medical Center **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**: 02/05/2024

**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 Verification

**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.**

DocuSigned by:
8C9B0AC01EFC400...

04/26/2024

*(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:**

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