SCL Health

To: **RAMOS LAW**
Company:
Fax: 303-865-5666
Phone:

From:
Fax:
Phone:
E-mail:

NOTES:

The information contained in this facsimile transmission is solely for the addressee(s) named above and is privileged and/or confidential.
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If you have received this communication in error, please notify us immediately by telephone for instructions. Thank you.

Date and time of transmission: Thursday, April 6, 2023 2:14:52 PM (MT)
Number of pages including this cover sheet: 05

SCL Health

4/6/23

Ramos Law
10190 BANNOCK ST
STE 200
Northglenn, Colorado 80260

Re: Request for Medical Record Copies from Platte Valley Medical Center- Health Information Management

At this time we are unable to answer your request for medical record copies concerning Theodore J Angel due to the following reason(s):

-We do not have any records, nor do we release records for Platte Valley Ambulance Service. You must contact them directly for any records/billing.

If you have any questions regarding this notice, please contact Centralized Release of Information by email peaks_croi@imail.org; or fax at 303-467-8966. Our office hours are Monday through Friday, 8:00 am to 4:00 p.m.

Sincerely,

Judy L
Centralized Release of Information Department

Ramos Law ATTN Medical records & billing custodian RE: Therodore James

Jonathan Madriz <jmadriz@ramoslaw.com>

Wed 4/5/2023 8:51 AM

To: 3036518166@rcfax.com <3036518166@rcfax.com>;Peaks_CROI <peaks_croi@imail.org>

1 attachments (391 KB)

2023.04.05 Platte Valley Ambulance Service MBR req .pdf;

External Sender: Be aware! Read with care!

Hello there, hope this message finds you well.

My name is Jonathan, and I am reaching out to you from Ramos Law. I would like to request the following information related to Theodore's ambulance service:

- Itemized billing and billing custodian with CPI and ICD 10 codes
- Complete medical chart

I have attached the relevant document to this message for your reference. Please let me know if you have any trouble accessing the attached file.

Once you have gathered the requested information, kindly confirm the receipt of this email and provide an estimated timeline for when we can expect to receive the requested documents.

Thank you for your time and cooperation. Please do not hesitate to contact me if you have any questions or concerns regarding this request.

Sincerely,

d:
o: 303.733.6353
f: 303.865.5666

Jonathan Madriz
Legal Assistant

RAMOS LAW

10190 Bannock St Suite 200
Northglenn, CO 80260
www.ramoslaw.com
Attorneys Licensed in 22 States

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RAMOS LAW
INJURY DIVISION

FAX

April 5, 2023
Platte Valley Ambulance Service
ATTN: Medical Records and Billing Custodian
Fax #: (303) 651-8166
FROM: Jonathan Madriz jmadriz@ramoslaw.com
RE: Theodore James Angel
Date of Birth: September 15, 1975
Date of Loss: February 23, 2023
Phone Number: (720) 685-8420

Our office represents the above named individual regarding injuries suffered on February 23, 2023.

We are requesting that you provide us the following information associated with their treatment:

1. ***Complete electronic file of medical records in CD form*** *including initial evaluation, treatment summary notes, referrals, prescriptions, laboratory and diagnostic testing recommendations and results, and all handwritten notes.*
2. **A complete itemized billing statement for all charges –** including those that may have been paid – *with* CPT and ICD-10 codes.
3. **Please send dates of service February 23, 2023.**

I have enclosed a signed *authorization for release of medical records* allowing you to release this information. Please bill our office for charges associated with the forwarding of these documents. **If you require pre-payment, cd for electronic transfer or DropBox information please email me the bill or fax charges to 303-865-5666. Please contact our office if copy charges are to exceed $50.00. We do not authorize any copies above this amount.**

If you are unable to comply with the thirty (30) day deadline for providing the requested medical records, we ask that you contact us in writing before the deadline expires. In your letter, you must provide a written statement of the reasons for the delay and the date by which you will provide the medical records. Under the HITECH Act, you are only provided one such extension of time.

If you have any questions concerning this request, please call me at (480) 877-9719 or e-mail jmadriz@ramoslaw.com. Thank you in advance for your assistance regarding this matter.

Sincerely,
Ramos Law
Jonathan Madriz

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Platte Valley Ambulance Service 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: 02/23/2023

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): Itemized billing statement with CPT and ICD- 10 codes and Complete medical chart

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)*

04/05/2023
(Date of Signature)

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