

February 1, 2024

ATTN: SUBROGATION  
CMS  
Medicare Secondary Payer Recovery  
*By fax – (405) 869-3309*

My Client:	Gustavo Alvarez
Date of Loss:	September 21, 2023
Date of Birth:	May 1, 1993
SS #:	638-42-1995

To Whom It May Concern:

This office represents the interests of Gustavo Alvarez, who was injured in an accident on September 21, 2023.

Our office is requesting a current ledger showing all bills received and all payments made related to the September 21, 2023 incident.

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

Sincerely,

RAMOS LAW

Andres Flores  
Client Relations Specialist

/af

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

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

**Patient Name:** Gustavo Alvarez **D.O.B.** May 1, 1993 **SS#** 638-42-1995

**Patient Street Address:** 16840 Wagon Train Loop **City:** Peyton  
**State:** CO **Zip Code:** 80831

**Date(s) of Treatment Requested:** 9/21/2023 to present.

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

- |                                                                                   |                                         |                                             |                                            |
|-----------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Discharge Summary                                        | <input type="checkbox"/> ER Record      | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Treatment Plans   |
| <input type="checkbox"/> Discharge Instructions                                   | <input type="checkbox"/> X-Rays Reports | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Commitment Papers |
| <input type="checkbox"/> History and Physical                                     | <input type="checkbox"/> Lab Reports    | <input type="checkbox"/> Doctor's Orders    | <input type="checkbox"/> HIV Testing       |
| <input type="checkbox"/> Consultations                                            | <input type="checkbox"/> EKG/ECG Tests  | <input type="checkbox"/> Nurse's Notes      |                                            |
| <input type="checkbox"/> Operative Report                                         | <input type="checkbox"/> Therapy Notes  |                                             |                                            |
| <input checked="" type="checkbox"/> Other (please specify): <u>Subro - Ledger</u> |                                         |                                             |                                            |

**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.

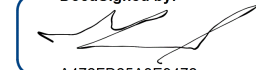
I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

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.



A472FD25A3E9472  
*(Signature of Patient or Personal Representative\*)*

02/01/2024

*(Date of Signature)*

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

- |                                        |                                             |                                                        |
|----------------------------------------|---------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Parent        | <input type="checkbox"/> Legal Guardian     | <input type="checkbox"/> Health Care Power of Attorney |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Executor of Estate | <input type="checkbox"/> Next of Kin                   |
|                                        |                                             | <input type="checkbox"/> Beneficiary                   |