May 10, 2024

ATTN: SUBROGATION
CMS
Attn: Recovery Department
By fax – (405) 869-3309

My Client:	Noel Alvarado
Date of Loss:	April 15, 2024
Date of Birth:	August 25, 1957
SS #:	521-65-9773

To Whom It May Concern:

This office represents the interests of Noel Alvarado, who was injured in an accident on April 15, 2024.

Please also accept this correspondence as our formal inquiry as to whether Noel Alvarado's policy is considered an ERISA plan. If yes, then we are requesting that the plan documents, including but not limited to the Summary of Benefits and Coverages and the applicable form 5500 filings be provided to our office within the next 30 days.

If you have any questions or need additional information, please call our office or email MCortez@Ramoslaw.com.

Sincerely,

RAMOS LAW

Manuel Cortez

Manuel Cortez
Legal Assistant

/MAC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize CMS **to release medical information from the records of:**

(Name of Facility)

Patient Name: Noel Alvarado **D.O.B.**August 25, 1957 **SS#** 521-65-9773

Patient Street Address: 5030 Broadway St **City**: Denver **State:** CO **Zip Code**: 80216

Date(s) of Treatment Requested: 2024/04/15 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 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:
744333841ECA41F...

05/10/2024

(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