RAMOS LAW
INJURY DIVISION

**FAX**

March 8, 2024
Panorama Orthopedics & Spine Center - Golden
660 Golden Ridge Road Ste #250
Golden, CO 80401
ATTN: Medical Records and Billing Custodian
Fax #: (720) 497-6726
FROM: Valentina Salas VSalas@ramoslaw.com
RE: Tamara Catherine Anderson
Date of Birth: August 14, 1996
Date of Loss: February 5, 2024
Phone Number: (303) 233-1223

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Our office represents the above named individual regarding injuries suffered on February 5, 2024.

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 from February 01, 2019 to February 01, 2024.**

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) 877-9727 or e-mail VSalas@ramoslaw.com. Thank you in advance for your assistance regarding this matter.

Sincerely,

Ramos Law

Valentina Salas

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**I hereby authorize** Panorama Orthopedics & Spine Center - Golden **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**: February 01, 2019 to February 01, 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): detailed itemized billing statement, including billing custodian information, CPI, and ICD-10 codes.

**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...

03/08/2024

*(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**