

FAX

June 27, 2024

Lutheran Medical Center
8300 W. 38th Avenue, Wheat Ridge, CO 80033
ATTN: Medical Records and Billing Custodian
Fax #: (303) 689-6661
FROM: Michel Estrada michel@ramoslaw.com
RE: Noel Alvarado
Date of Birth: August 25, 1957
Date of Loss: April 15, 2024
Phone Number: (303) 425-4500
Pages: 2

Our office represents the above named individual regarding injuries suffered on April 15, 2024. We are requesting that you provide us the following information associated with their treatment:

1. ***Complete file of medical records*** 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 April 15, 2024 to present.**

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 (720) 536-4373 or e-mail michel@ramoslaw.com. Thank you in advance for your assistance regarding this matter.

Ramos Law

Michel Estrada
Paralegal

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Lutheran Medical Center **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: 4/15/2024 - current

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

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

 Designated by:

744933841ECA41F
 (Signature of Patient or Personal Representative*)

6/27/2024

(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

From: [RingCentral](#)
To: [Michel Estrada](#)
Subject: Fax Message Transmission Result to +1 (303) 6896661 - Sent
Date: Thursday, June 27, 2024 8:44:47 AM



Fax Transmission Result

Here are the results of the 3-page fax you sent from your phone number **(888) 418-9896, Ext. 4373**

Name	Phone Number	Date and Time	Result
3036896661@rcfax.com	+1 (303) 6896661	Thursday, June 27, 2024 at 7:44 AM	Sent

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File Name	Result
2024.06.27 - Lutheran MC req.pdf	Success

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