

TX Result Report

P 1
01/27/2026 09:44
Serial No. A8KN015001185
TC: 92673

Addressee	Start Time	Time	Prints	Result	Note
18555228152	01-27 09:42	00:02:04	002/002	OK	

Note

TMR:Timer TX, POL:Polling, ORG:Original Size Setting, FME:Frame Erase TX,
DPG:Page Separation TX, MIX:Mix Original TX, CALL:Manual TX, CSAC:CSAC,
FWD:Forward, PC:PC-FAX, BND:Double-Sided Binding Direction, SP:Special Original,
FCODE:F-code, RTX:Re-TX, RLV:Relay, MBX:Confidential, BUL:Bulletin, SIP:SIP Fax,
IPADR:IP Address Fax, I-FAX:Internet Fax

Result

OK: Communication OK, S-OK: Stop Communication, PW-OFF: Power Switch OFF,
TEL: RX from TEL, NG: Other Error, CONT: Continue, No Ans: No Answer,
Refuse: Receipt Refused, Busy: Busy, M-Full:Memory Full, LOVR:Receiving length Over,
POVR:Receiving page Over, FTL:File Error, DC:Decode Error, MDN:MDN Response Error,
DSN:DSN Response Error, PRINT:Compulsory Memory Document Print,
DEL:Compulsory Memory Document Delete, SEND:Compulsory Memory Document Send.

GRABB & DURANDO, P.C.

PERSONAL INJURY ATTORNEYS

January 27, 2026

Northwest Urgent Care
1218 W. Irvington Rd. Suite 150
Tucson, AZ 85714

Via Fax to (855) 522-8152

REQUEST FOR MEDICAL RECORDS AND ITEMIZED BILLING STATEMENTS

Re: *Our Client:* *Luis Nichols*
 Date of Birth: *July 1, 2006*
 Date of Accident: *October 6, 2025*

Dear Custodian of Records:

Please be advised that this firm represents **Luis Nichols** for injuries suffered in an automobile accident as referenced above. It is our understanding you rendered medical services to our client. **Please forward medical records and itemized billing statements to include all dates of service beginning with the date of accident listed above to the present regarding accident-related treatment of our client.** Enclosed is an authorization to release complete medical records and itemized billing statements.

We are now accepting records via email in Acrobat pdf format, send to avazquez@grabblaw.com. You may also forward copies of the above records to my office address: **2929 E. Broadway Blvd. Tucson, AZ 85716**. In the event you require prepayment, please fax your invoice to our new fax number **888-778-1472** and we will remit payment.

If copying charges exceed \$50.00, we request that you contact our office prior to copying for fee approval.

We are expecting to receive these records in our office by **February 27, 2026**. Please call if that deadline cannot be met. Thank you for your kind attention to this matter.

Sincerely,

GRABB & DURANDO, PC

Ana Vazquez

Paralegal to Robert M. Grabb, Esq.

/pg
Enclosure

Robert M. Grabb, Esq.
2929 E. BROADWAY BLVD, TUCSON AZ 85716
520.222.2222 GRABBLAW.COM 520.333.3333

Facsimile: 888.778.1472

GRABB & DURANDO, P.C.

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**HIPAA COMPLIANT AUTHORIZATION TO USE OR DISCLOSE PROTECTED
INFORMATION IN DIGITAL FORMAT**

Patient Name: Luis Nichols

Health Record Number:

Date of Birth: 07/01/2006

SSN: XXX-XX-9286

1. Grabb & Durando, PC is authorized to request records on my behalf in digital format per the Federal HITECH Act.

2. The following named individual or organization is authorized to make a disclosure:

Name: Northwest Urgent Care
Address: 1218 W. Irvington Rd. Suite 150
Tucson, Arizona 85714

3. The type and amount of information to be used or disclosed is my *entire medical record (including billing & pharmacy), school records, financial records and employment records.*

4. I authorize the provider to use or disclose information related to:

- ☒ AIDS/HIV and other Communicable Diseases
- ☒ Behavioral Healthcare/Psychiatric Care
- ☒ Alcohol and/or Drug Abuse Treatment
- ☒ Genetic Testing Information

5. This information shall be provided to, disclosed to and used by Grabb & Durando, PC for the purpose of legal advice and/or pursuing a personal injury claim, including litigation.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire at the *conclusion of my personal injury claim or discharge as representative of the personal injury claim.* **Photocopies of this authorization shall have the same effect and validity as the original.** (If I fail to specify an expiration date, event or condition, this authorization will expire in six months; for drug and alcohol records this authorization will expire in 60 days).

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Healthcare Provider regarding their privacy practices.

Luis Nichols
Signature of Patient or Legal Representative

DATED: 01/27/2026

If Signed by Legal Representative, Relationship to Patient

Signature of Witness