03/19/2026 14:14
Serial No. A8KN015001185
TC: 96916

Addressee	Start Time	Time	Prints	Result	Note
15203767825	03-19 14:13	00:01:10	002/002	OK	

Note TMR:Timer TX, POL:Polling, ORG:Original Size Setting, FME:Frame Erase TX, DPG:Page Separation TX, MIX:Mixed Original TX, CALL:Manual TX, CSRC:CSRC, FWD:Forward, PC:PC-FAX, BND:Double-Sided Binding Direction, SP:Special Original, FCODE:F-code, RTX:Re-TX, RLY: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, FIL: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

March 19, 2026

Northwest Medical Center Outpatient Therapy
6130 N. La Cholla Blvd. Suite 135B
Tucson, Arizona 85741

Via Facsimile to (520) 376-7825

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 have 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 **rpesqueira@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 **April 19, 2026**. Please call if that deadline cannot be met. Thank you for your kind attention to this matter.

Sincerely,

GRABB & DURANDO, PC

Reyna Pesqueira
Paralegal to Robert M. Grabb, Esq.

/rp
Enclosure

GRABB & DURANDO, P.C.

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Sincerely,

GRABB & DURANDO, PC

Reyna Pesqueira
Paralegal to Robert M. Grabb, Esq.

/rp
Enclosure

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 Medical Center Outpatient Therapy
   Address 6130 N. La Cholla Blvd., Ste 135B
   Tucson, Arizona 85741

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 **DATED:** 03/19/26

Signature of Patient or Legal Representative

If Signed by Legal Representative, Relationship to Patient

Signature of Witness