

Addressee	Start Time	Time	Prints	Result	Note
15204698151	03-25 10:50	00:01:20	002/002	OK	

Note TMR:Timer TX, POL:Polling, ORG:Original Size Setting, FME:Frame Erase TX, PPS:Page Separation TX, MIX:Mixed 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, RLY:Relay, MEX: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 25, 2026

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

Via Facsimile to (520) 469-8151

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 25, 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.

PERSONAL INJURY ATTORNEYS

March 25, 2026

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

Via Facsimile to (520) 469-8151

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 25, 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

Robert M. Grabb, Esq.	
2929 E. BROADWAY BLVD, TUCSON AZ 85716	
Ph. 520.222.2222	GRABBLAW.COM Fax. 888.778.1472

**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: NW Medical Center Physical 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
Signature of Patient or Legal Representative

DATED: 03/25/2026

If Signed by Legal Representative, Relationship to Patient

Signature of Witness