



Order Number: 12301-01
Records Subject: Peter Schack
Date of Birth: 02/17/1978

Date: 07/23/2026

Records Due Before
08/05/2026

To: Dobbins Fire Protection District
9150 Marysville Road
Oregon House, CA 95962
Attn: Medical Records

(44-2026a)

Record Retrieval Solutions is requesting copies of the following records:

Medical Records,Billing Records
Records requested from 04/01/2015 through 07/22/2026

We have provided several options for you to easily send the requested records. If you have Electronic Records, please keep them paperless.

- Upload records via our HIPAA compliant secure site www.recordrs.com/upload.
- Send records via encrypted email to sendrecords@recordsync.io
- Mail records preferably on a CD or thumb drive to the address listed below.
- Fax records to (904) 578-7447.

For any fees over \$15.00 please send us an invoice for approval that meets your state's guidelines

Thank you for your assistance. If you need to contact us, please call (904) 914-9184 or email us at status@recordrs.com.

Mailing Address: 4237 Salisbury Road, Suite 403 Jacksonville, FL 32216



149 Court Street, Auburn, CA 95603
Telephone: 530-745-6861
Facsimile: 530-745-6862
Email: info@maurer.law
www.maurer.law

July 15, 2026

Re: Record Retrieval Solutions Letter of Representation

To whom it may concern:

Record Retrieval Solutions is hereby authorized to represent Maurer Law Corporation in the acquisition of records. Any request(s) for records conveyed on behalf of Maurer Law Corporation through Record Retrieval Solutions should be considered the same as a direct request from Maurer Law Corporation.

If you have any questions, please do not hesitate to contact me.

MAURER LAW CORPORATION

By: _____

JORDAN W. MAURER, ESQ.

**AUTHORIZATION FOR INSPECTION, COPY AND
DISCLOSURE OF HEALTH INFORMATION (HIPAA 164, 508, ET SEQ.)**

Patient Name: Peter Schach

Date of Birth: 2 17 78

Medical Record # (If Applicable): _____

SSN: 569812006

1. I hereby authorize the inspection, copying and disclosure of the above-named individual's health information as described in Section 3 below:

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

(Name) Dobbins Fire Protection District (Address) 9150 Marysville Road, Oregon House, CA 95962

3. This authorization permits the inspection, copying and disclosure of the following information:

☐ All health information in your possession or under your control pertaining to any examinations, findings, diagnoses, prognoses and treatment of me and the billing for such care or treatment, from treatment of me and the billing for such care or treatment, from _____ to the present.

☐ All health information in your possession or under your control pertaining to any examinations, findings, diagnoses, prognoses and treatment of me and billing for such care or treatment, at any time. Any and all Medical Records from 04/01/2015 to 07/22/2026 and Billing Records from 07/01/2025 to 07/23/2026.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the **Maurer Law Corporation, 149 Court Street, Auburn, CA 95603 for Legal purposes.**

Record Retrieval Solutions 4237 Salisbury Road Suite 403 Jacksonville FL 32216

6. I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing and that it complies with any specific requirements of the individual or organization making or using the disclosure. I understand that the revocation will not apply to information that has already been released in response to this authorization.

**AUTHORIZATION FOR INSPECTION, COPY AND DISCLOSURE OF HEALTH INFORMATION
(HIPAA 164, 508, ET SEQ.)**

7. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that such information may not be protected by federal confidentiality rules.
8. Unless otherwise revoked, this authorization will expire two years from the date of execution indicated below.
9. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.

A copy of this authorization is as valid as the original.



Signature of Patient or Representative

07/22/2026

Date

Peter Schack

Printed Name of Patient or Representative

Relationship of
Representative to Patient