SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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LISA M. D'AVANZO,

Plaintiff,

-against-

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD OF NASSAU COUNTY, INC., BRONWYN FITZ, M.D., NASSAU HEALTH CARE CORPORATION, d/b/a NASSAU UNIVERSITY MEDICAL CENTER, IRWIN GOLDSTEIN, M.D., and LONG ISLAND OB GYN ASSOCIATES,

Defendants.

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Index No. 613549/2017

RESPONSE TO COMBINED DEMANDS

PLEASE TAKE NOTICE that the following is plaintiff's response to the combined demands of defendants:

AS AND FOR A RESPONSE TO DEMAND FOR ATTORNEYS APPEARING

The names and addresses of the attorneys appearing in this action are listed below.

AS AND FOR A RESPONSE TO DEMAND FOR AUTHORIZATIONS

Attached hereto are duly executed authorizations to obtain the medical records from the following providers:

a. Nassau University Medical Center
2201 Hempstead Turnpike
East Meadow, NY 11554

b. Planned Parenthood of Nassau County (Bronwyn Fitz, M.D.)
540 Fulton Avenue
Hempstead, NY 11550

c. South Nassau Communities Hospital
1 Healthy Way
Oceanside, NY 11572

d. Irwin Goldstein, M.D.
Long Island OB GYN Associates
79 Grand Avenue
Massapequa, NY 11758

AS AND FOR A RESPONSE TO DEMAND FOR EXPERT INFORMATION

Expert information will be supplied under separate cover.

AS AND FOR A RESPONSE TO DEMAND FOR WITNESS INFORMATION

The names and addresses of witnesses will be supplied under separate cover.

AS AND FOR A RESPONSE TO DEMAND FOR CERTIFICATE OF MERIT

Please find enclosed a copy of the certificate of merit.

AS AND FOR A RESPONSE TO DEMAND FOR ADVERSE PARTY STATEMENTS

Plaintiff is not in possession of any adverse party statements, save the medical records and hospital records of the defendants.

AS AND FOR A RESPONSE TO DEMAND FOR PHOTOGRAPHS AND VIDEOS

Plaintiff is not in possession of any photographs or videos.

AS AND FOR A RESPONSE TO DEMAND FOR COLLATERAL SOURCE INFORMATION

Collateral source information will be supplied under separate cover.

Plaintiff is not a Medicare recipient.

Dated: July 30, 2018
Islandia, New York

Yours, etc.

RAPPAPORT, GLASS, LEVINE & ZULLO, LLP

BY: _____
THOMAS P. VALET
Attorneys for Plaintiff
1355 Motor Parkway
Islandia, NY 11749
(631) 293-2300

TO: Heidell, Pittoni, Murphy & Bach, LLP and Long Island OB GYN Associates
Attorney For: Irwin Goldstein, M.D.
1050 Franklin Avenue
Garden City, NY 11530-1760
Phone: (516) 408-1600

Kerley, Walsh, Matera & Cinquemani, P.C.
Attorney For: Nassau Health Care Corporation d/b/a Nassau University Medical Center
2174 Jackson Avenue
Seaford, NY 11783-2608
Phone: (516) 409-6200

McAloon & Friedman, P.C.
Attorney For: Planned Parenthood of Nassau County, Inc.
123 William Street, 25th Floor
New York, NY 10038-3804
Phone: (212) 732-8700

POWER OF ATTORNEY

To Execute HIPAA Medical Record Authorization Forms Pursuant to New York Public Health Law §18(1)(g) as Amended 10/26/04

I, Lisa D'Avanzo

do hereby appoint CHARLES J. RAPPAPORT, MICHAEL G. GLASS, MICHAEL S. LEVINE, MATTHEW J. ZULLO, CHRISTOPHER M. GLASS, MARY ANN RISAVICH-BIRGELES, THOMAS P. VALET of RAPPAPORT, GLASS, LEVINE & ZULLO, LLP, with offices at 1355 Motor Parkway, Islandia, NY 11749, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally to execute HIPAA medical record authorization forms pursuant to New York Public Health Law §18(1)(g) as amended 10/26/04. This power of attorney may be revoked by me at any time. This Power of Attorney shall not be affected by subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof I have hereunto signed my name this 21st day of March, 20 17.

(signature)

Acknowledgment

STATE OF NEW YORK)
)ss.:
COUNTY OF)

On this 21st day of March, 20 17, before me personally appeared Lisa D'Avanzo, known to be, or provided to me on the basis of satisfactory evidence, to be the individual whose name is subscribed to in the within instrument and acknowledged to me that executed the same in his/her capacity, and that by his/her individual signature, executed this instrument and that such individual made such appearance before the undersigned at Islandia, New York.

Notary Public

THERESA M. MURPHY
Notary Public, State of New York
No. 4892670
Qualified in Nassau County
Commission Expires May 11, 2019

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
Nassau University Medical Center, 2201 Hempstead Turnpike, East Meadow, NY 11554

8. Name and address of person(s) or category of person to whom this information will be sent:
McAloon & Friedman, P.C., 123 William Street, 25th Floor, New York, NY 10038

9(a). Specific information to be released:
□ Medical information from (insert date _____ to (insert date) _____
x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _____
_____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted]988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
Planned Parenthood of Nassau County (Bronwyn Fitz, M.D.), 540 Fulton Avenue, Hempstead, NY 11550

8. Name and address of person(s) or category of person to whom this information will be sent:
McAloon & Friedman, P.C., 123 William Street, 25th Floor, New York, NY 10038

9(a). Specific information to be released:
□ Medical information from (insert date _____ to (insert date) _____
x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:
1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
South Nassau Communities Hospital, 1 Healthy Way, Oceanside, NY 11572

8. Name and address of person(s) or category of person to whom this information will be sent:
McAloon & Friedman, P.C., 123 William Street, 25th Floor, New York, NY 10038

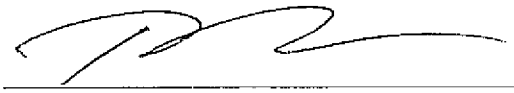
9(a). Specific information to be released:
□ Medical information from (insert date _____ to (insert date) _____
x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.



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Signature of Patient or Representative authorized by law.

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[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

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7. Name and address of health provider or entity to release this information:
Irwin Goldstein, M.D., Long Island OB GYN Associates, 79 Grand Avenue, Massapequa, NY 11758

8. Name and address of person(s) or category of person to whom this information will be sent:
McAloon & Friedman, P.C., 123 William Street, 25th Floor, New York, NY 10038

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

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8. Name and address of person(s) or category of person to whom this information will be sent:
Kerley, Walsh, Matera & Cinquemani, P.C., 2174 Jackson Avenue, Seaford, NY 11783

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x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
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Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
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Signature of Patient or Representative authorized by law.

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted], 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

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7. Name and address of health provider or entity to release this information:
Planned Parenthood of Nassau County (Bronwyn Fitz, M.D.), 540 Fulton Avenue, Hempstead, NY 11550

8. Name and address of person(s) or category of person to whom this information will be sent:
Kerley, Walsh, Matera & Cinquemani, P.C., 2174 Jackson Avenue, Seaford, NY 11783

9(a). Specific information to be released:
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x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
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Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
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Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
South Nassau Communities Hospital, 1 Healthy Way, Oceanside, NY 11572

8. Name and address of person(s) or category of person to whom this information will be sent:
Kerley, Walsh, Matera & Cinquemani, P.C., 2174 Jackson Avenue, Seaford, NY 11783

9(a). Specific information to be released:

□ Medical information from (insert date _____ to (insert date) _____

x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other: _____

_____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

10. Reason for release of information:	11. Date or event on which this authorization will expire:
□ At request of individual x Other: Lawsuit related	At conclusion of lawsuit
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Thomas P. Valet	Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
Irwin Goldstein, M.D., Long Island OB GYN Associates, 79 Grand Avenue, Massapequa, NY 11758

8. Name and address of person(s) or category of person to whom this information will be sent:
Kerley, Walsh, Matera & Cinquemani, P.C., 2174 Jackson Avenue, Seaford, NY 11783

9(a). Specific information to be released:
□ Medical information from (insert date _____ to (insert date) _____
x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
Nassau University Medical Center, 2201 Hempstead Turnpike, East Meadow, NY 11554

8. Name and address of person(s) or category of person to whom this information will be sent:
Heidell, Pittoni, Murphy & Bach, LLP, 1050 Franklin Avenue, Garden City, NY 11530

9(a). Specific information to be released:
□ Medical information from (insert date _____ to (insert date) _____
x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
Planned Parenthood of Nassau County (Bronwyn Fitz, M.D.), 540 Fulton Avenue, Hempstead, NY 11550

8. Name and address of person(s) or category of person to whom this information will be sent:
Heidell, Pittoni, Murphy & Bach, LLP, 1050 Franklin Avenue, Garden City, NY 11530

9(a). Specific information to be released:

□ Medical information from (insert date _____ to (insert date) _____

x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted] 1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
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3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
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5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
South Nassau Communities Hospital, 1 Healthy Way, Oceanside, NY 11572

8. Name and address of person(s) or category of person to whom this information will be sent:
Heidell, Pittoni, Murphy & Bach, LLP, 1050 Franklin Avenue, Garden City, NY 11530

9(a). Specific information to be released:

□ Medical information from (insert date _____ to (insert date) _____

x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other: _____

_____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

10. Reason for release of information:	11. Date or event on which this authorization will expire:
□ At request of individual x Other: Lawsuit related	At conclusion of lawsuit
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Thomas P. Valet	Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Lisa D'Avanzo	Date of Birth [redacted]1988	Social Security Number
Patient Address 933 Grant Place, Bellmore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
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1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
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3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
Irwin Goldstein, M.D., Long Island OB GYN Associates, 79 Grand Avenue, Massapequa, NY 11758

8. Name and address of person(s) or category of person to whom this information will be sent:
Heidell, Pittoni, Murphy & Bach, LLP, 1050 Franklin Avenue, Garden City, NY 11530

9(a). Specific information to be released:
□ Medical information from (insert date _____ to (insert date) _____
x Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _____
_____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information
(b) □ By initialing here _____ I authorize _____
initial Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
_____

10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire: At conclusion of lawsuit
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: July 30, 2018
Signature of Patient or Representative authorized by law.

*Human Immunodeficiency that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AFFIDAVIT OF SERVICE

STATE OF NEW YORK, COUNTY OF SUFFOLK ss.:

Diana Rybacki, being duly sworn, deposes and says: deponent is not a party to the action, is of 18 years of age and resides at Smithtown, New York.

On Monday, July 30, 2018 deponent served the within RESPONSE TO COMBINED DEMANDS upon:

Heidell, Pittoni, Murphy & Bach, LLP
Attorney For: Irwin Goldstein, M.D. and Long Island OB GYN Associates
1050 Franklin Avenue
Garden City, NY 11530-1760
Phone: (516) 408-1600

Kerley, Walsh, Matera & Cinquemani, P.C.
Attorney For: Nassau Health Care Corporation d/b/a Nassau University Medical Center
2174 Jackson Avenue
Seaford, NY 11783-2608
Phone: (516) 409-6200

McAloon & Friedman, P.C.
Attorney For: Planned Parenthood of Nassau County, Inc.
123 William Street, 25th Floor
New York, NY 10038-3804
Phone: (212) 732-8700

the address designated by said attorneys for the purpose, by depositing a true copy of same in a post-paid properly addressed wrapper, in an official depository under the exclusive care and custody of the United States Postal Service within the State of New York.

Diana Rybacki

Sworn to before me on Monday, July 30, 2018

Notary Public

EMMA M. NARAIN
Notary Public, State of New York
No. 01NA6185272
Qualified in Nassau County
Commission Expires April 14, 2020