FILED: NEW YORK COUNTY CLERK 05/22/2012

NYSCEF DOC. NO. 10-2

INDEX NO. 150347/2011

RECEIVED NYSCEF: 05/22/2012

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
-----X
SHARA DEJESUS,

Index No.: 150347/11

Plaintiff,

VERIFIED BILL OF PARTICULARS

against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Defendants. -----X

Plaintiff, SHARA DEJESUS, by her attorney, the LAW OFFICE OF ROBERT F. DANZI, as and for her Response to Demand for a Verified Bill of Particulars of defendant, BHANUMATHY VINAYAGASUNDARAM, M.D., sets forth as follows:

- a) Upon information and belief, the negligent acts and/or omissions charged against defendant, BHANUMATHY VINAYAGASUNDARAM, M.D., occurred from March 8, 2010 up to and including June 2011.
 - b) The negligent acts and/or omissions charged against defendant,

 BHANUMATHY VINAYAGASUNDARAM, M.D., took place at

 QUEENS LONG ISLAND MEDICAL GROUP, P.C., located at 640

 Hawkins Avenue, Ronkonkoma, New York 11779.
- 2. Defendant, BHANUMATHY VINAYAGASUNDARAM, M.D., his agents, servants and/or employees were negligent and careless in the care and treatment of plaintiff, SHARA DEJESUS: in failing to take a proper history; in failing to take a proper history which would have included a history of recent termination of pregnancy; in failing to take a proper

history, specifically failing to inquire and note the absence of menses; in failing to perform a proper physical examination; in failing to have a proper and appropriate index of suspicion in light of plaintiff's recent termination of pregnancy; in failing to perform a proper diagnosis in not identifying that plaintiff was pregnant; in failing to perform a pelvic sonogram; in failing to order a pelvic sonogram; in failing to perform a proper pelvic examination; in failing to properly screen for malignant neoplasm; in failing to properly work up complaints of left inguinal pain; in failing to properly work up complaints of lower back pain; in failing to properly consider that plaintiff had a procedure to evacuate her uterus during the month of February 2010; in failing to properly evaluate plaintiff's leiomyoma of the uterus; in failing to properly work up plaintiff's dysfunctional uterine bleeding; in failing to properly work up plaintiff's dyspareunia; in failing to work up and investigate the absence of menses; in failing to perform a proper blood work up including but not limited to tests to determine plaintiff's HCG levels and other measures to confirm or rule out pregnancy; in failing to note and investigate plaintiff's fever; in failing order proper medications specifically antibiotics; in failing to treat plaintiff who called with fever and post-operative signs and symptoms of infection; in failing to perform a proper differential diagnosis; in failing to properly treat infection; in failing to properly diagnose infection; in failing to properly investigate the signs and symptoms of infection; in failing to adequately clear plaintiff for surgery; in failing to maintain an adequate index of suspicion; in failing and neglecting to timely, adequately, and properly perform, request, obtain, use, utilize, administer and/or evaluate necessary diagnostic examinations, tests and/or consultations; in failing and neglecting to keep adequate, complete, accurate, thorough and relevant records and notes upon which to rely, or to otherwise adequately memorialize and/or record relevant information, history, complaints, signs, symptoms and findings; in failing to properly correlate and/or

evaluate the findings and history obtained; in failing to obtain necessary, timely and/or adequate consultation with other medical professionals; in failing to use and employ the best medical judgment; in failing to properly interpret diagnostic and laboratory tests and studies; in failing to fully appreciate the significance of plaintiff's presenting condition; in failing and/or neglecting to expect, anticipate and/or foresee the danger, risk, harm and injury; in failing to take all necessary steps to timely and/or properly correct and/or repair plaintiff's presenting condition; in failing and/or neglecting to use reasonable care and/or diligence in safeguarding and/or protecting plaintiff; in failing to administer, recommend and/or ensure administration and recommendation of proper course of medical and treatment for plaintiff's presenting condition; in failing to keep abreast of current medical customs and practice; in failing to perform necessary and/or further diagnostic work-up and/or treatment in a timely and/or diligent fashion and/or ensure performance of same; in failing to possess the degree of medical skill and knowledge necessary under the circumstances; in allowing the plaintiff to languish without appropriate medical care; in failing to arrange for follow-up care; in negligently allowing plaintiff's condition to deteriorate; in failing to timely and properly formulate a differential diagnosis; in failing to timely and properly recognize the significance of, determine the etiology of and act upon plaintiff's presenting condition; in lack of informed consent; and in failing to disclose to the plaintiff alternatives to treatment rendered and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed in a manner permitting the plaintiff to make a knowledgeable evaluation.

3. This demand is palpably improper pursuant to *Dellaglio v. Paul*, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and *Patterson v. Jewish Hospital & Medical Center of*

Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, *aff'd*, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "2" above.

- 4. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "2" above.
- 5. Left inguinal pain, lower back pain, fever, signs and symptoms of infection, and all complaints, signs and symptoms contained within the John T. Mather Memorial Hospital chart.
- 6. As a result of the carelessness, negligence and malpractice of defendant,
 BHANUMATHY VINAYAGASUNDARAM, M.D., his agents, servants and/or employees,
 plaintiff, SHARA DEJESUS, sustained the following serious and permanent personal injuries:
 - failed termination of pregnancy;
 - endometritis;
 - anemia;
 - blood loss;
 - severe sepsis;
 - fever and chills;
 - temperature of 106;
 - need for cooling blanket and ice packs;
 - profound hypovolemia;
 - hyronephrosis and hydroureter;
 - enlarged uterus

	-	total abdominal hysterectomy*;
	_	hormonal changes as a consequence of hysterectomy*;
٠	-	hemodynamic instability;
	-	infection;
	-	need for transfusions;
	-	need for antibiotics;
	_	sterility*;
	-	vaginal bleeding;
	-	pain;
		vaginal discharge;
	<u>~</u>	palpitations
	u in	emotional pain;
	-	sexual avoidance;
	-	protracted hospitalization;
	-	disorientation;
	-	abdominal swelling;
	-	need to undergo repeat abortion;
	-	need for unnecessary surgeries;
	-	economic loss;
	-	loss of income.
	All in	uries with an asterisk (*) are permanent in nature.
	7.	Dr. Elizabeth Jeremias located at 640 Hawkins Ave., Ronkonkoma, New York;

Dr. Michael A. Lee located at 640 Hawkins Ave., Ronkonkoma, New York; Dr. Palivan located

at 640 Hawkins Ave., Ronkonkoma, New York; Dr. Richard Rose located at 5400 Nesconset Highway, Port Jefferson Station, New York 11776; Dr. Stanley Ostrow located at 235 N. Belle Mead Road, East Setauket, New York 11733; and Dr. Phillibert located at 6 Technology Drive East Setauket, New York 11733.

- 8. Plaintiff, SHARA DEJESUS, was confined to John T. Mather Memorial Hospital located at 75 North Country Road, Port Jefferson, New York 11777, on April 13, 2010 and from June 8, 2010 up to and including June 25, 2010; The Mount Sinai Hospital located at 1 Gustave L Levy Place, New York, New York 10029 from June 1, 2010 up to and including June 5, 2010; and Stony Brook University Hospital located at Nicolls Road, Stony Brook, New York from November 27, 2010 up to and including December 6, 2010.
 - 9. a) See paragraph "8" above.
 - b) Plaintiff, SHARA DEJESUS, was confined to her home for approximately six months.
 - Plaintiff, SHARA DEJESUS, was confined to her bed for approximately two months.
- Plaintiff, SHARA DEJESUS, date of birth is January 15, 1967 she resides at 338
 Boyle Road, Selden, New York 11784.
- 11. Plaintiff has no knowledge of the names, addresses, physical appearances and/or occupations of each and every person who performed such acts and/or omissions other than the named defendants herein. It will be claimed that the named defendants are vicariously liable for the acts and/or omissions of their partners, agents, servants and/or employees, including the named individuals who treated plaintiff, and whose names, identities and descriptions are not

known to plaintiff, but whose names appear on the medical and hospital records and are known more readily to the answering defendant.

- a) Stony Brook University Hospital located at 101 Nicolls Road, Stony Brook, New York 11790.
 - b) Nurses Station Clerk.
 - c) Upon information and belief, \$28,649.00.
 - d) Plaintiff, SHARA DEJESUS's last date of work was on April 12, 2010.
 - e) To be provided.
 - f) From April 12, 2010 up to and including March 14, 2011.
- 13. a-e, g) Special damages are currently unknown but would be the amounts of bills incurred by plaintiff from the defendants herein, any hospitals and doctors she has or will treat with in relation to the malpractice. Plaintiff is currently not in possession of same. However, once received, the amounts will be included in a Supplemental Bill of Particulars.
 - f) Not applicable.
- 14. Not applicable.
- 15. This demand is palpably improper as it seeks disclosure of items inappropriate for a bill of particulars and not discoverable under CPLR Article 30, *Bharwani v. Rosario*, 180 A.D.2d 704, 579 N.Y.S.2d 727 (2d Dept.1992). Not foregoing this objection, an authorization for HIP has been provided.
- 16. Defendants, their agents, servants and/or employees were negligent in failing to properly inform plaintiff of the risks, hazards, complications and potential complications arising from the performance of the treatment rendered herein; failing to disclose to the plaintiff

alternatives to the treatment rendered and the reasonably foreseeable risks, benefits and alternatives involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the plaintiff to make a knowledgeable evaluation. Had such risk been disclosed, plaintiff would not have undergone the treatment rendered. This demand is rejected in all other aspects as inappropriate for bill of particulars and objected to as evidentiary in nature.

- 17. See paragraph "16" above.
- 18. Plaintiff, SHARA DEJESUS' social security number is 133-66-9924.
- 19. Not applicable.

Plaintiff reserves her right to amend and/or supplement this response upon completion of discovery up to and through the trial of this matter.

Dated: Westbury, New York March 19, 2012

LAW OFFICE OF ROBERT F. DANZI

Attorney for Plaintiff

900 Merchants Concourse, Suite 314

Westbury, New York 11590

(516) 228-4226

TO: SILVERSON, PARERES & LOMBARDI, LLP

Attorneys for Defendant

MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYSGASUNDARAM, M.D. and

QUEENS LONG ISLAND MEDICAL GROUP, P.C.

192 Lexington Avenue, 17th Floor

New York, New York 10016

(212) 557-1818

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant THE MOUNT SINAI HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600 ATTORNEY'S VERIFICATION

CHRISTINE COSCIA, an attorney duly admitted to practice in the county of New

York affirms under penalties of perjury:

I am an associate with the LAW OFFICE OF ROBERT F. DANZI, attorney for

plaintiff.

I have read the attached BILL OF PARTICULARS and know the contents thereof;

it is true to my own knowledge, except as to the matters therein alleged to be on information and

belief, and as to those matters I believe them to be true. This verification is made by me because

plaintiff does not reside within the county where we maintain our office.

Dated: Westbury, New York March 19, 2012

(Hussia

CHRISTINE COSCIA

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

Kathleen Chiddo, being sworn, says:

I am not a party to the action, am over 18 years of age and reside at Bethpage, New York.

On March 19, 2012 I served the within

VERIFED BILL OF PARTICULARS

by depositing a true copy thereof enclosed in a post-paid wrapper, in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State, addressed to each of the following persons at the last known address set forth herein, as follows:

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP Attorneys for Defendants QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., and BHANUMATHY VINAYAGASUNDARAM, M.D., 192 Lexington Avenue, 17th Floor New York, NY 10016 (212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant THE MOUNT SINAI HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600

Kathleen Chiddo

Sworn to before me this day of March, 2012

Notary Public

MARCI VELLA Notary Public, State of New York No. 01VE6066189

Qualified in Naspau County Commission Expires November 13, 20

INDEX NO.: 150347/11 SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF SUFFOLK

SHARA DEJESUS.

Plaintiff,

- against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Defendants.

VERIFIED BILL OF PARTICULARS

Law Office of Robert F. Danzi Attorney for Plaintiff 900 Merchants Concourse, Suite 314 Westbury, New York 11590 T: (516) 228-4226

1: (516) 228-4226 F: (516) 228-6569 SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
-----X

SHARA DEJESUS,

Index No.: 150347/11

Plaintiff,

VERIFIED BILL OF PARTICULARS

- against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Detendants.	*	
,		v

Plaintiff, SHARA DEJESUS, by her attorney, the LAW OFFICE OF ROBERT F.

DANZI, as and for her Response to Demand for a Verified Bill of Particulars of defendant,

JOHN T. MATHER MEMORIAL HOSPITAL, sets forth as follows:

1. Defendant, JOHN T. MATHER MEMORIAL HOSPITAL, its agents, servants and/or employees were negligent and careless in the care and treatment of plaintiff, SHARA DEJESUS: in failing to take a proper history to establish her then current pregnancy; in failing to diagnose pregnancy; in failing to appreciate the history of abortion that was elicited; in failing to establish the date when the prior abortion was performed; in failing to elicit a more detailed history after prior abortion including last menstrual period when it was determined that x-ray was needed; in failing to establish pregnancy before performing x-rays and other diagnostic tests and procedures; in failing to perform a proper differential diagnosis; in failing to appreciate the date of her last menstrual period; in failing to appreciate the significance of intermenstrual bleeding starting February 27, 2010; in failing to appreciate the low levels of Hg/Hct revealed in the CBC performed; in failing to appreciate the abnormal kidney function values; in failing to perform

sonogram or ultrasound; in failing to perform MRI study; in failing to diagnose and treat genitourniary infection; in failing to diagnose and treat kidney infection; in discharging plaintiff prematurely; in discharging plaintiff with evidence of active infection; in failing to perform timely culture and sensitivities; in failing to perform proper culture and sensitivities; in failing to order proper antibiotic therapy; in failing to obtain proper and timely consultations; in failing to perform a proper urological workup; in failing to place a stent to relieve fluid buildup in the kidneys; in failing to place Nephrostomy tube; in discharging plaintiff with fever; in failing to appreciate the history that was received; in failing to maintain an adequate index of suspicion; in failing and neglecting to timely, adequately, and properly perform, request, obtain, use, utilize, administer and/or evaluate necessary diagnostic examinations, tests and/or consultations; in failing and neglecting to keep adequate, complete, accurate, thorough and relevant records and notes upon which to rely, or to otherwise adequately memorialize and/or record relevant information, history, complaints, signs, symptoms and findings; in failing to properly correlate and/or evaluate the findings and history obtained; in failing to obtain necessary, timely and/or adequate consultation with other medical professionals; in failing to use and employ the best medical judgment; in failing to maintain a suitable index of suspicion; in failing to properly interpret diagnostic and laboratory tests and studies; in failing to fully appreciate the significance of plaintiff's presenting condition; in failing and/or neglecting to expect, anticipate and/or foresee the danger, risk, harm and injury; in failing to take all necessary steps to timely and/or properly correct and/or repair plaintiff's presenting condition; in failing and/or neglecting to use reasonable care and/or diligence in safeguarding and/or protecting plaintiff; in failing to administer, recommend and/or ensure administration and recommendation of proper course of medical and/or surgical care and treatment for plaintiff's presenting condition; in failing to keep

abreast of current medical customs and practice; in failing to perform necessary and/or further diagnostic work-up and/or treatment in a timely and/or diligent fashion and/or ensure performance of same; in failing to possess the degree of medical skill and knowledge necessary under the circumstances; in allowing the plaintiff to languish without appropriate medical care; in failing to form proper differential diagnoses and treatment; in failing to arrange for follow-up care; in negligently allowing plaintiff's condition to deteriorate; in failing to timely and properly formulate a differential diagnosis; in failing to timely and properly recognize the significance of, determine the etiology of and act upon plaintiff's presenting condition; in lack of informed consent; and in failing to disclose to the plaintiff alternatives to treatment rendered and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed in a manner permitting the plaintiff to make a knowledgeable evaluation.

- 2. Upon information and belief, the negligent acts and/or omissions charged against defendant, JOHN T. MATHER MEMORIAL HOSPITAL occurred on April 13, 2010 and from June 8, 2010 up to and including June 25, 2010.
- 3. The negligent acts and/or omissions charged against defendant, JOHN T. MATHER MEMORIAL HOSPITAL, took place at JOHN T. MATHER MEMORIAL HOSPITAL located at 75 North Country Road, Port Jefferson, New York 11777.
- 4. Plaintiff has no knowledge of the names, addresses, physical appearances and/or occupations of each and every person who performed such acts and/or omissions other than the named defendants herein. It will be claimed that the named defendants are vicariously liable for the acts and/or omissions of their partners, agents, servants and/or employees, including the named individuals who treated plaintiff, and whose names, identities and descriptions are not

known to plaintiff, but whose names appear on the medical and hospital records and are known more readily to the answering defendant.

- 5. This demand is palpably improper pursuant to *Dellaglio v. Paul*, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and *Patterson v. Jewish Hospital & Medical Center of Brooklyn*, 94 Misc.2d 680, 405 N.Y.S.2d 194, *aff'd*, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "1" above.
- 6. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "1" above.
- 7. Plaintiff makes no claim for improper or defective equipment at this time, but reserves her right to amend pending completion of discovery.
- 8. Plaintiff does not claim defendant violated any laws of the State of New York at this time.
- 9. Plaintiff, SHARA DEJESUS, was confined to John T. Mather Memorial Hospital located at 75 North Country Road, Port Jefferson, New York 11777, on April 13, 2010 and June 8, 2010 up to and including June 25, 2010; The Mount Sinai Hospital located at 1 Gustave L Levy Place, New York, New York 10029 on June 1, 2010 and June 4, 2010 up to and including June 5, 2010; and Stony Brook University Hospital located at Nicolls Road, Stony Brook, New York from November 27, 2010 up to and including December 6, 2010.
- 10. As a result of the carelessness, negligence and malpractice of defendant, JOHN T MATHER MEMORIAL HOSPITAL, its agents, servants and/or employees, plaintiff, SHARA DEJESUS, sustained the following serious and permanent personal injuries:

-	endometritis;
-	anemia;
-	blood loss;
-	severe sepsis;
-	fever and chills;
-	temperature of 106;
-	need for cooling blanket and ice packs;
-	profound hypovolemia;
-	hyronephrosis and hydroureter;
-	enlarged uterus
-	total abdominal hysterectomy*;
-	hormonal changes as a consequence of hysterectomy*;
-	hemodynamic instability;
	hemodynamic instability; infection;
-	
-	infection;
- - -	infection; need for transfusions;
- - -	infection; need for transfusions; need for antibiotics;
- - -	infection; need for transfusions; need for antibiotics; sterility*;
- - -	infection; need for transfusions; need for antibiotics; sterility*; vaginal bleeding;
- - -	infection; need for transfusions; need for antibiotics; sterility*; vaginal bleeding; pain;
- - - -	infection; need for transfusions; need for antibiotics; sterility*; vaginal bleeding; pain; vaginal discharge;

failed termination of pregnancy;

- sexual avoidance;
- protracted hospitalization;
- disorientation;
- abdominal swelling;
- need to undergo repeat abortion;
- need for unnecessary surgeries;
- economic loss;
- loss of income.

All injuries with an asterisk (*) are permanent in nature.

- 11. Plaintiff, SHARA DEJESUS, date of birth is January 15, 1967, her social security number is 133-66-9924 and she resides at 338 Boyle Road, Selden, New York 11784.
- 12. Plaintiff will rely upon the doctrine of res ipsa loquitur based on the fact that she went in for a termination of pregnancy and came out still pregnant.
- 13. Defendants, their agents, servants and/or employees were negligent in failing to properly inform plaintiff of the risks, hazards, complications and potential complications arising from the performance of the treatment rendered herein; failing to disclose to the plaintiff alternatives to the treatment rendered and the reasonably foreseeable risks, benefits and alternatives involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the plaintiff to make a knowledgeable evaluation. Had such risk been disclosed, plaintiff would not have undergone the treatment rendered. This demand is rejected in all other aspects as inappropriate for bill of particulars and objected to as evidentiary in nature.
 - 14. Heart palpitations and failed termination of pregnancy on April 13, 2010; and

in June 2010, severe abdominal pain, cramping, fever, clots, bleeding, infection and all complaints, signs and symptoms contained within the John T. Mather Memorial Hospital chart.

- 15. a) See paragraph "9" above.
 - b) Plaintiff, SHARA DEJESUS, was confined to her home for approximately six months.
 - e) Plaintiff, SHARA DEJESUS, was confined to her bed for approximately two months.
- 16. a) Plaintiff, SHARA DEJESUS, was unable to work for approximately eleven months.
 - b) Plaintiff, SHARA DEJESUS' last date of work was on April 12, 2010.
 - c) Plaintiff, SHARA DEJESUS returned to work on March 14, 2011
 - d) Plaintiff, SHARA DEJESUS's bi-weekly earnings were approximately \$1,306.15.
 - e) Stony Brook University Hospital located at 101 Nicolls Road, Stony Brook, New York 11790 as a Nurses Station Clerk.
- 17. a-d, f) Special damages are currently unknown but would be the amounts of bills incurred by plaintiff from the defendants herein, any hospitals and doctors she has or will treat with in relation to the malpractice. Plaintiff is currently not in possession of same. However, once received, the amounts will be included in a Supplemental Bill of Particulars.
 - e) To be provided.
- 18. Not applicable.

- 19. This demand is palpably improper as it seeks disclosure of items inappropriate for a bill of particulars and not discoverable under CPLR Article 30, *Bharwani v. Rosario*, 180 A.D.2d 704, 579 N.Y.S.2d 727 (2d Dept.1992). Not foregoing this objection, an authorization for HIP has been provided.
 - 20. Plaintiff, SHARA DEJESUS' social security number is 133-66-9924.

Plaintiff reserves her right to amend and/or supplement this response upon completion of discovery up to and through the trial of this matter.

Dated: Westbury, New York March 19, 2012

LAW OFFICE OF ROBERT F. DANZI

Attorney for Plaintiff

900 Merchants Concourse, Suite 314

Westbury, New York 11590

(516) 228-4226

TO: FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP
Attorneys for Defendants
QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D.,
and BHANUMATHY VINAYAGASUNDARAM, M.D.,
192 Lexington Avenue, 17th Floor
New York, NY 10016
(212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant THE MOUNT SINAL HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600 ATTORNEY'S VERIFICATION

CHRISTINE COSCIA, an attorney duly admitted to practice in the county of New

York affirms under penalties of perjury:

I am an associate with the LAW OFFICE OF ROBERT F. DANZI, attorney for

plaintiff.

I have read the attached BILL OF PARTICULARS and know the contents thereof;

it is true to my own knowledge, except as to the matters therein alleged to be on information and

belief, and as to those matters I believe them to be true. This verification is made by me because

plaintiff does not reside within the county where we maintain our office.

Dated: Westbury, New York

March 19, 2012

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

Kathleen Chiddo, being sworn, says:

I am not a party to the action, am over 18 years of age and reside at Bethpage, New York.

On March 19, 2012 I served the within

VERIFED BILL OF PARTICULARS

by depositing a true copy thereof enclosed in a post-paid wrapper, in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State, addressed to each of the following persons at the last known address set forth herein, as follows:

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP
Attorneys for Defendants
QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D.,
and BHANUMATHY VINAYAGASUNDARAM, M.D.,
192 Lexington Avenue, 17th Floor
New York, NY 10016
(212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant THE MOUNT SINAI HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600

Cathleen Chiddo

Sworn to before me this 19th day of March, 2012

Notaly Public

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County

Commission Expires Nevamber 13, 2

INDEX NO.: 150347/11

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF SUFFOLK .

SHARA DEJESUS.

Plaintiff,

- against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINA! HOSPITAL and MIRIAM CREMER, M.D.,

Defendants.

VERIFIED BILL OF PARTICULARS

Law Office of Robert F. Danzi
Attorney for Plaintiff
900 Merchants Concourse, Suite 314
Westbury, New York 11590
T: (516) 228-4226
F: (516) 228-6569

SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF NEW YORK -----X

SHARA DEJESUS,

Index No.: 150347/11

Plaintiff,

VERIFIED BILL OF PARTICULARS

- against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Defendants.

Plaintiff, SHARA DEJESUS, by her attorney, the LAW OFFICE OF ROBERT F.

DANZI, as and for her Response to Demand for a Verified Bill of Particulars of defendant, THE

MOUNT SINAI HOSPITAL sets forth as follows:

- a) Upon information and belief, the negligent acts and/or omissions charged against defendant, THE MOUNT SINAI HOSPITAL occurred from June 1, 2010 up to and including June 5, 2010.
 - b) The negligent acts and/or omissions charged against defendant, THE

 MOUNT SINAI HOSPITAL, took place at THE MOUNT SINAI

 HOSPITAL located at 1 Gustave L Levy Place, New York, New York

 10029.
- 2. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.

- 3. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff d, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.
- 4. Plaintiff makes no claim for improper or defective equipment at this time, but reserves her right to amend pending completion of discovery.
- 5. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.
- 6. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.
- 7. Defendant, THE MOUNT SINAI HOSPITAL, its agents, servants and/or employees were negligent and careless in the care and treatment of plaintiff, SHARA DEJESUS: in failing to take into account the pre-existent topography of plaintiff's uterus, specifically fibroids, in performing and planning for the procedure pre, intra and post operatively; in failing to take into consideration plaintiff's anemia; in failing to perform proper pre-operative evaluation; in failing to perform proper pre-operative and post-operative blood evaluations to establish infection and anemia; in failing to adequately clear plaintiff for surgery; in failing to perform a proper sonographic/ultrasound evaluation of plaintiff pre, intra and post procedure; in failing to properly use ultra-sonography intra-procedure to assist in the performance of the evacuation; in failing to appreciate the extent of blood loss; in failing to take into consideration

fibroids in plaintiff's uterus in planning for and performing the procedure in question; in failing to properly use the instruments of extraction in light of the pre-existing fibrotic condition of plaintiff's uterus; in failing to appreciate the damage and injury to plaintiff's uterus as a result of failing to appreciate and take into consideration the topography of plaintiff's uterus in light of the fibroids present; in failing to render post-operative treatment in light of damage to the uterus as a result of failing to plan for the presence of the fibroids; in failing to provide adequate antibiotic coverage in light of the disruption to the interior surfaces of the uterus as a result of the excessive instrumentation employed due to the failure to appreciate the topography of the uterus caused by the fibroids pre-procedure, post-procedure and on discharge; in failing to provide proper antibiotics pre, intra and post procedure; in failing to forego the placement of IUD due to the same being contraindicated due to the difficulty in removing the placenta and the heavy bleeding then present, and the condition of the uterus as a result of the surgical procedure employed and the pre-existent fibroids; in failing to adequately replace blood loss; in failing to properly administer blood products; in failing to perform an adequate and proper discharge evaluation; in failing to treat hemodynamic instability; in failing to correct dropping Hg/Hct; in discharging plaintiff prematurely; in failing to obtain proper and timely CBC's to assess hemodynamic stability: in failing to properly chart plaintiff's condition; in failing to maintain an adequate index of suspicion; in failing and neglecting to timely, adequately, and properly perform, request, obtain, use, utilize, administer and/or evaluate necessary diagnostic examinations, tests and/or consultations; in failing and neglecting to keep adequate, complete, accurate, thorough and relevant records and notes upon which to rely, or to otherwise adequately memorialize and/or record relevant information, history, complaints, signs, symptoms and findings; in failing to properly correlate and/or evaluate the findings and history obtained; in failing to obtain necessary, timely and/or adequate consultation with other medical professionals; in failing to use

and employ the best medical judgment; in failing to properly interpret diagnostic and laboratory tests and studies; in failing to fully appreciate the significance of plaintiff's presenting condition; in failing and/or neglecting to expect, anticipate and/or foresee the danger, risk, harm and injury; in failing to take all necessary steps to timely and/or properly correct and/or repair plaintiff's condition; in failing and/or neglecting to use reasonable care and/or diligence in safeguarding and/or protecting plaintiff; in failing to administer, recommend and/or ensure administration and recommendation of proper course of medical and surgical treatment for plaintiff's condition; in failing to keep abreast of current medical customs and practice; in failing to perform necessary and/or further diagnostic work-up and/or treatment in a timely and/or diligent fashion and/or ensure performance of same; in failing to possess the degree of medical skill and knowledge necessary under the circumstances; in allowing the plaintiff to languish without appropriate medical care; in failing to arrange for follow-up care; in negligently allowing plaintiff's condition to deteriorate; in failing to timely and properly formulate a differential diagnosis; in failing to timely and properly recognize the significance of, determine the etiology of and act upon the plaintiff's condition; in lack of informed consent; and in failing to disclose to the plaintiff alternatives to treatment rendered and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed in a manner permitting the plaintiff to make a knowledgeable evaluation.

8. Plaintiff has no knowledge of the names, addresses, physical appearances and/or occupations of each and every person who performed such acts and/or omissions other than the named defendants herein. It will be claimed that the named defendants are vicariously liable for the acts and/or omissions of their partners, agents, servants and/or employees, including the named individuals who treated plaintiff, and whose names, identities and descriptions are not

known to plaintiff, but whose names appear on the medical and hospital records and are known more readily to the answering defendant.

- 9. a) As a result of the carelessness, negligence and malpractice of defendant,
 THE MOUNT SINAI HOSPITAL, its agents, servants and/or employees, plaintiff, SHARA
 DEJESUS, sustained the following serious and permanent personal injuries:
 - failed termination of pregnancy;
 - endometritis;
 - anemia;
 - blood loss;
 - severe sepsis;
 - fever and chills;
 - temperature of 106;
 - need for cooling blanket and ice packs;
 - profound hypovolemia;
 - hyronephrosis and hydroureter;
 - enlarged uterus
 - total abdominal hysterectomy*;
 - hormonal changes as a consequence of hysterectomy*;
 - hemodynamic instability;
 - infection;
 - need for transfusions;
 - need for antibiotics;
 - sterility*;
 - vaginal bleeding;

- pain;
- vaginal discharge;
- palpitations
- emotional pain;
- sexual avoidance;
- protracted hospitalization;
- disorientation;
- abdominal swelling;
- need to undergo repeat abortion;
- need for unnecessary surgeries;
- economic loss;
- loss of income.
- b) All injuries with an asterisk (*) are permanent in nature.
- 10. a) Plaintiff, SHARA DEJESUS, was confined to her bed for approximately two months.
 - b) Plaintiff, SHARA DEJESUS, was confined to her home for approximately six months.
 - Plaintiff, SHARA DEJESUS, was confined to John T. Mather Memorial Hospital located at 75 North Country Road, Port Jefferson, New York 11777, on April 13, 2010 and from June 8, 2010 up to and including June 25, 2010; The Mount Sinai Hospital located at 1 Gustave L Levy Place, New York, New York 10029 from June 1, 2010 up to and including June 5, 2010; and Stony Brook University Hospital located at Nicolls Road,

Stony Brook, New York from November 27, 2010 up to and including December 6, 2010.

- d) Not applicable.
- incurred by plaintiff from the defendants herein, any hospitals and doctors she has or will treat with in relation to the malpractice. Plaintiff is currently not in possession of same. However, once received, the amounts will be included in a Supplemental Bill of Particulars.
 - e) If any, to be provided.
 - a) Nurses Station Clerk. Stony Brook University Hospital located at 101
 Nicolls Road, Stony Brook, New York 11790.
 - b) See paragraph "12a" above.
 - c) Not applicable.
 - d) From April 12, 2010 up to and including March 14, 2011.
 - e) Upon information and belief, \$28,649.00.
 - f) To be provided.
 - g) If any, will be provided.
 - 13. Plaintiff, SHARA DEJESUS' date of birth is January 15, 1967.
 - 14. Plaintiff, SHARA DEJESUS' social security number is 133-66-9924.
 - 15. 338 Boyle Road, Selden, New York 11784.
- 16. This demand is palpably improper as it seeks disclosure of items inappropriate for a bill of particulars and not discoverable under CPLR Article 30, *Bharwani v. Rosario*, 180 A.D.2d 704, 579 N.Y.S.2d 727 (2d Dept.1992). Not foregoing this objection, an authorization for HIP has been provided.

17. Defendants, their agents, servants and/or employees were negligent in failing to properly inform plaintiff of the risks, hazards, complications and potential complications arising from the performance of the treatment rendered herein; failing to disclose to the plaintiff alternatives to the treatment rendered and the reasonably foreseeable risks, benefits and alternatives involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the plaintiff to make a knowledgeable evaluation. Had such risk been disclosed, plaintiff would not have undergone the treatment rendered. This demand is rejected in all other aspects as inappropriate for bill of particulars and objected to as evidentiary in nature.

- 18. See paragraph "17" above.
- 19. See paragraph "17" above.
- 20. See paragraph "17" above.
- 21. See paragraph "17" above.
- 22. See paragraph "17" above.
- 23. See paragraph "17" above.

Plaintiff reserves her right to amend and/or supplement this response upon completion of discovery up to and through the trial of this matter.

Dated: Westbury, New York March 19, 2012

LAW OFFICE OF ROBERT F. DANZI

Attorney for Plaintiff

900 Merchants Concourse, Suite 314

Westbury, New York 11590

(516) 228-4226

TO: KAUFMAN, BORGEEST & RYAN, LLP
Attorneys for Defendant
THE MOUNT SINAI HOSPITAL
120 Broadway, 14th Floor
New York, New York 10271
(212) 980-9600

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP
Attorneys for Defendants
QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D.,
and BHANUMATHY VINAYAGASUNDARAM, M.D.,
192 Lexington Avenue, 17th Floor
New York, NY 10016
(212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700 ATTORNEY'S VERIFICATION

CHRISTINE COSCIA, an attorney duly admitted to practice in the county of New

York affirms under penalties of perjury:

I am an associate with the LAW OFFICE OF ROBERT F. DANZI, attorney for

plaintiff.

I have read the attached BILL OF PARTICULARS and know the contents thereof;

it is true to my own knowledge, except as to the matters therein alleged to be on information and

belief, and as to those matters I believe them to be true. This verification is made by me because

plaintiff does not reside within the county where we maintain our office.

Dated: Westbury, New York

March 19, 2012

CHRISTINE COSCIA

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

Kathleen Chiddo, being sworn, says:

I am not a party to the action, am over 18 years of age and reside at Bethpage, New York.

On March 19, 2012 I served the within

VERIFED BILL OF PARTICULARS

by depositing a true copy thereof enclosed in a post-paid wrapper, in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State, addressed to each of the following persons at the last known address set forth herein, as follows:

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP
Attorneys for Defendants
QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D.,
and BHANUMATHY VINAYAGASUNDARAM, M.D.,
192 Lexington Avenue, 17th Floor
New York, NY 10016
(212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant THE MOUNT SINAI HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600

Kathleen Chiddo

Sworn to before me this 19% day of March, 2012

Notary Public

MARCI VELLA
Notary Public, State of New York

No. 01VE6066189

Qualified in Nassal County

Commission Expires Nevember y 3, 26

INDEX NO.: 150347/11 SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF SUFFOLK

SHARA DEJESUS,

Plaintiff,

- against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Defendants.

VERIFIED BILL OF PARTICULARS

Law Office of Robert F. Danzi
Attorney for Plaintiff
900 Merchants Concourse, Suite 314
Westbury, New York 11590
T: (516) 228-4226
E: (516) 228-6569

SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF NEW YORK -----X SHARA DEJESUS, Index No.: 150347/11

Plaintiff,

VERIFIED BILL OF PARTICULARS

against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Defendants.

Plaintiff, SHARA DEJESUS, by her attorney, the LAW OFFICE OF ROBERT F. DANZI, as and for her Response to Demand for a Verified Bill of Particulars of defendant, MIRIAM CREMER, M.D. sets forth as follows:

- a) Upon information and belief, the negligent acts and/or omissions charged against defendant, MIRIAM CREMER, M.D. at The Mount Sinai Hospital occurred from June 1, 2010 up to and including June 5, 2010.
 - b) The negligent acts and/or omissions charged against defendant, MIRIAM CREMER, M.D., took place at THE MOUNT SINAI HOSPITAL located at 1 Gustave L Levy Place, New York, New York 10029.
- 2. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.
- 3. This demand is palpably improper pursuant to *Dellaglio v. Paul*, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and *Patterson v. Jewish Hospital & Medical Center of*

Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.

- 4. Plaintiff makes no claim for improper or defective equipment at this time, but reserves her right to amend pending completion of discovery.
- 5. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.
- 6. This demand is palpably improper pursuant to Dellaglio v. Paul, 250 A.D.2d 806, 673 N.Y.S.2d 212 (2d Dept. 1998) and Patterson v. Jewish Hospital & Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194, aff'd, 65 A.D.2d 553, 409 N.Y.S.2d 124 (2d Dept. 1978). Not foregoing this objection, see paragraph "7" below.
- 7. Defendant, MIRIAM CREMER, M.D., her agents, servants and/or employees were negligent and careless in the care and treatment of plaintiff, SHARA DEJESUS: in failing to take into account the pre-existent topography of plaintiff's uterus, specifically fibroids, in performing and planning for the procedure pre, intra and post operatively; in failing to take into consideration plaintiff's anemia; in failing to perform proper pre-operative evaluation especially in light of the knowledge of the failure of the procedure performed on February 27, 2010; in failing to perform proper pre-operative and post-operative blood evaluations to establish infection and anemia; in failing to adequately clear plaintiff for surgery; in failing to perform a proper sonographic/ultrasound evaluation of plaintiff pre, intra and post procedure; in failing to properly use ultra-sonography intra-procedure to assist in the performance of the evacuation especially in light of the knowledge of the failure of the procedure performed on February 27, 2010; in failing to appreciate the extent of blood loss; in failing to take into consideration

fibroids in plaintiff's uterus in planning for and performing the procedure in question especially in light of the knowledge of the failure of the procedure performed on February 27, 2010; in failing to properly use the instruments of extraction in light of the pre-existing fibrotic condition of plaintiff's uterus especially in light of the knowledge of the failure of the procedure performed on February 27, 2010; in failing to appreciate the damage and injury to plaintiff's uterus as a result of failing to appreciate and take into consideration the topography of plaintiff's uterus in light of the fibroids present especially in light of the knowledge of the failure of the procedure performed on February 27, 2010; in failing to render post-operative treatment in light of damage to the uterus as a result of failing to plan for the presence of the fibroids especially in light of the knowledge of the failure of the procedure performed on February 27, 2010; in failing to provide adequate antibiotic coverage in light of the disruption to the interior surfaces of the uterus as a result of the excessive instrumentation employed due to the failure to appreciate the topography of the uterus caused by the fibroids pre-procedure, post-procedure and on discharge; in failing to provide proper antibiotics pre, intra and post procedure; in failing to forego the placement of IUD due to the same being contraindicated due to the difficulty in removing the placenta and the heavy bleeding then present, and the condition of the uterus as a result of the surgical procedure employed and the pre-existent fibroids; in failing to adequately replace blood loss; in failing to properly administer blood products; in failing to perform an adequate and proper discharge evaluation; in failing to treat hemodynamic instability; in failing to correct dropping Hg/Hct; in discharging plaintiff prematurely; in failing to obtain proper and timely CBCs to assess hemodynamic stability; in failing to properly chart plaintiff's condition; in failing to maintain an adequate index of suspicion; in failing and neglecting to timely, adequately, and properly perform, request, obtain, use, utilize, administer and/or evaluate necessary diagnostic examinations, tests and/or consultations; in failing and neglecting to keep adequate, complete,

accurate, thorough and relevant records and notes upon which to rely, or to otherwise adequately memorialize and/or record relevant information, history, complaints, signs, symptoms and findings; in failing to properly correlate and/or evaluate the findings and history obtained; in failing to obtain necessary, timely and/or adequate consultation with other medical professionals; in failing to use and employ the best medical judgment; in failing to properly interpret diagnostic and laboratory tests and studies; in failing to fully appreciate the significance of plaintiff's presenting condition; in failing and/or neglecting to expect, anticipate and/or foresee the danger, risk, harm and injury; in failing to take all necessary steps to timely and/or properly correct and/or repair plaintiff's condition; in failing and/or neglecting to use reasonable care and/or diligence in safeguarding and/or protecting plaintiff; in failing to administer, recommend and/or ensure administration and recommendation of proper course of medical and surgical treatment for plaintiff's condition; in failing to keep abreast of current medical customs and practice; in failing to perform necessary and/or further diagnostic work-up and/or treatment in a timely and/or diligent fashion and/or ensure performance of same; in failing to possess the degree of medical skill and knowledge necessary under the circumstances; in allowing the plaintiff to languish without appropriate medical care; in failing to arrange for follow-up care; in negligently allowing plaintiff's condition to deteriorate; in failing to timely and properly formulate a differential diagnosis; in failing to timely and properly recognize the significance of, determine the etiology of and act upon the plaintiff's condition; in lack of informed consent; and in failing to disclose to the plaintiff alternatives to treatment rendered and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed in a manner permitting the plaintiff to make a knowledgeable evaluation.

8. Plaintiff has no knowledge of the names, addresses, physical appearances and/or occupations of each and every person who performed such acts and/or omissions other than the

named defendants herein. It will be claimed that the named defendants are vicariously liable for the acts and/or omissions of their partners, agents, servants and/or employees, including the named individuals who treated plaintiff, and whose names, identities and descriptions are not known to plaintiff, but whose names appear on the medical and hospital records and are known more readily to the answering defendant.

- 9. a) As a result of the carelessness, negligence and malpractice of defendant, MIRIAM CREMER, M.D., her agents, servants and/or employees, plaintiff, SHARA DEJESUS, sustained the following serious and permanent personal injuries:
 - failed termination of pregnancy;
 - endometritis;
 - anemia;
 - blood loss;
 - severe sepsis;
 - fever and chills;
 - temperature of 106;
 - need for cooling blanket and ice packs;
 - profound hypovolemia;
 - hyronephrosis and hydroureter;
 - enlarged uterus
 - total abdominal hysterectomy*;
 - hormonal changes as a consequence of hysterectomy*;
 - hemodynamic instability;
 - infection;
 - need for transfusions;

- need for antibiotics;
- sterility*;
- vaginal bleeding;
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- vaginal discharge;
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- sexual avoidance;
- protracted hospitalization;
- disorientation;
- abdominal swelling;
- need to undergo repeat abortion;
- need for unnecessary surgeries;
- economic loss;
- loss of income.
- b) All injuries with an asterisk (*) are permanent in nature.
- 10. a) Plaintiff, SHARA DEJESUS, was confined to her bed for approximately two months.
 - b) Plaintiff, SHARA DEJESUS, was confined to her home for approximately six months.
 - Plaintiff, SHARA DEJESUS, was confined to John T. Mather Memorial
 Hospital located at 75 North Country Road, Port Jefferson, New York
 11777, on April 13, 2010 and from June 8, 2010 up to and including June
 25, 2010; The Mount Sinai Hospital located at 1 Gustave L Levy Place,

New York, New York 10029 from June 1, 2010 up to and including June 5, 2010; and Stony Brook University Hospital located at Nicolls Road, Stony Brook, New York from November 27, 2010 up to and including December 6, 2010.

- d) Not applicable.
- 11. a-d,f) Special damages are currently unknown but would be the amounts of bills incurred by plaintiff from the defendants herein, any hospitals and doctors she has or will treat with in relation to the malpractice. Plaintiff is currently not in possession of same. However, once received, the amounts will be included in a Supplemental Bill of Particulars.
 - e) If any, to be provided.
 - a) Nurses Station Clerk. Stony Brook University Hospital located at 101
 Nicolls Road, Stony Brook, New York 11790.
 - b) See paragraph "12a" above.
 - c) Not applicable.
 - d) From April 12, 2010 up to and including March 14, 2011.
 - e) Upon information and belief, \$28,649.00.
 - f) To be provided.
 - g) If any, will be provided.
 - 13. Plaintiff, SHARA DEJESUS' date of birth is January 15, 1967.
 - 14. Plaintiff, SHARA DEJESUS' social security number is 133-66-9924.
 - 15. 338 Boyle Road, Selden, New York 11784.
- 16. This demand is palpably improper as it seeks disclosure of items inappropriate for a bill of particulars and not discoverable under CPLR Article 30, *Bharwani v. Rosario*, 180

A.D.2d 704, 579 N.Y.S.2d 727 (2d Dept.1992). Not foregoing this objection, an authorization for HIP has been provided.

17. Defendants, their agents, servants and/or employees were negligent in failing to properly inform plaintiff of the risks, hazards, complications and potential complications arising from the performance of the treatment rendered herein; failing to disclose to the plaintiff alternatives to the treatment rendered and the reasonably foreseeable risks, benefits and alternatives involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the plaintiff to make a knowledgeable evaluation. Had such risk been disclosed, plaintiff would not have undergone the treatment rendered. This demand is rejected in all other aspects as inappropriate for bill of particulars and objected to as evidentiary in nature.

- 18. See paragraph "17" above.
 - 19. See paragraph "17" above.
 - 20. See paragraph "17" above.
- 21. See paragraph "17" above.
- 22. See paragraph "17" above.
- 23. See paragraph "17" above.

Plaintiff reserves her right to amend and/or supplement this response upon completion of discovery up to and through the trial of this matter.

Dated: Westbury, New York May 21, 2012

LAW OFFICE OF ROBERT F. DANZI

Attorney for Plaintiff

900 Merchants Concourse, Suite 314

Westbury, New York 11590

(516) 228-4226

TO: KAUFMAN, BORGEEST & RYAN, LLP
Attorneys for Defendant
MIRIAM CREMER, M.D. and THE MOUNT SINAI HOSPITAL
120 Broadway, 14th Floor
New York, New York 10271
(212) 980-9600

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP
Attorneys for Defendants
QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D.,
and BHANUMATHY VINAYAGASUNDARAM, M.D.,
192 Lexington Avenue, 17th Floor
New York, NY 10016
(212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700 ATTORNEY'S VERIFICATION

ROBERT F. DANZI, an attorney duly admitted to practice in the county of New

York affirms under penalties of perjury:

I am the principal of the LAW OFFICE OF ROBERT F. DANZI, attorney for

plaintiff.

I have read the attached BILL OF PARTICULARS and know the contents thereof; it is true

to my own knowledge, except as to the matters therein alleged to be on information and belief, and

as to those matters I believe them to be true. This verification is made by me because plaintiff

does not reside within the county where we maintain our office.

Dated: Westbury, New York May 21, 2012

ROBERT F. DANZI

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

Kathleen Chiddo, being sworn, says:

I am not a party to the action, am over 18 years of age and reside at Bethpage, New York.

On May 21, 2012 I served the within

VERIFED BILL OF PARTICULARS

by depositing a true copy thereof enclosed in a post-paid wrapper, in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State, addressed to each of the following persons at the last known address set forth herein, as follows:

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd.
Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP
Attorneys for Defendants
QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D.,
and BHANUMATHY VINAYAGASUNDARAM, M.D.,
192 Lexington Avenue, 17th Floor
New York, NY 10016
(212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant MIRIAM CREMER, M.D. and THE MOUNT SINAI HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600

Kathleen Chiddo

Sworn to before me this 21st day of March, 2012

Notary Public

MARCI VELLA Notary Public, State of New York No. 01VE6066189

Qualified in Nassau County Commission Expires November (3) 20____ INDEX NO.: 150347/11

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF SUFFOLK

SHARA DEJESUS,

Plaintiff,

- against -

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Defendants.

VERIFIED BILL OF PARTICULARS

Law Office of Robert F. Danzi
Attorney for Plaintiff
900 Merchants Concourse, Suite 314
Westbury, New York 11590
T: (516) 228-4226
F: (516) 228-6569

SHARA DEJESUS,		Index No.: 150347/11
- against -	Plaintiff,	PLAINTIFF'S RESPONSE TO COMBINED DEMANDS
PLANNED PARENTHOOD INC., "JOHN DOE", M.D., Q MEDICAL GROUP, P.C., M BHANUMATHY VINAYAC JOHN T. MATHER MEMOR MOUNT SINAI HOSPITAL M.D.,	QUEENS LONG ISLAND ICHAEL ALAN LEE, M.D., GASUNDARAM, M.D., RIAL HOSPITAL, THE	
	Defendants.	

DEMAND FOR AUTHORIZATIONS

Enclosed are the following authorizations:

- The Mount Sinai Hospital
- Miriam Cremer MD

PECONIC, INC., set forth as follows:

- John T. Mather Memorial Hospital
- Planned Parenthood Hudson Peconic
- Evan Geller MD
- Mobin Sadiq MD
- Robert Derman MD
- Queens Long Island Medical Group
- Michael Alan Lee MD

- Bhanumathy Vinayagasundaram MD
- Dana Brenner MD
- Yanira Raza MD
- Dr. Elizabeth Jeremias
- Dr. Palivan
- Dr. Richard Rose
- Dr. Stanley Ostrow
- Dr. Phillibert
- Stony Brook University Hospital
- HIP Pharmacy
- Medical Group Pharmacy
- Prescription Den

DEMAND FOR EXPERT WITNESS INFORMATION

Plaintiff has not, as of this date, retained the services of an expert witness for the purposes of providing testimony. Plaintiff will advise defendants of the retention but no later than a reasonable time before trial. Plaintiff by this response, in no way waives her right to retain said experts and adduce their testimony at trial.

DEMAND FOR DAMAGES

Plaintiff has been damaged in the amount of FIVE MILLION (\$5,000,000.00) DOLLARS.

DEMAND FOR STATEMENTS

Plaintiffs are not in possession of any statements.

DEMAND FOR WITNESSES

Plaintiff is not in possession of the names of any witnesses. Plaintiff reserves the right to supplement their response after defendants' depositions are conducted.

DEMAND FOR COLLATERAL SOURCE INFORMATION

Enclosed is an authorization for HIP.

NOTICE TO PRODUCE

- 1. Plaintiff is not in possession of any photographs or videotapes responsive to this demand.
- 2. When plaintiff determines what will be introduced into evidence at trial, same will be provided to defendants pursuant to CPLR.
 - 3. Enclosed is an authorization for Medicaid.
 - 4. Upon information and belief, BZ41670G.
 - 5. 133-66-9924.
 - 6. Plaintiff is not in possession of any documents responsive to this demand.
 - 7. Enclosed is an authorization for Medicaid.

Dated: Westbury, New York March 12, 2012

LAW OFFICE OF ROBERT F. DANZI

Attorney for Plaintiff

900 Merchants Concourse, Suite 314

Westbury, New York 11590

(516) 228-4226

TO: MCALOON & FRIEDMAN, P.C.

Attorneys for Defendant

PLANNED PARENTHOOD HUDSON PECONIC, INC.

123 William Street-25th Floor

New York, New York 10038

(212) 732-8700

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant THE MOUNT SINAI HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600

SILVERSON, PARERES & LOMBARDI, LLP
Attorneys for Defendant
MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYSGASUNDARAM, M.D. and
QUEENS LONG ISLAND MEDICAL GROUP, P.C.
192 Lexington Avenue, 17th Floor
New York, New York 10016
(212) 557-1818

FUMUSO, KELLY, DEVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, New York 11788 (631) 232-0200



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address	-	
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF	R GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).	
7. Name and address of health provider or entity to release this info The Mount Sinai Hospital, One Gustave L. Levy Place,	New York, New York 10029	
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F	is information will be sent: loor, New York, NY 10038	
9(a). Specific information to be released:	•	
☐ Medical Record from (insert date)	to (insert date)	
Entire Medical Record, including patient histories, office ne referrals, consults, billing records, insurance records, and re	otes (except psychotherapy notes), test results, radiology studies, films, ecords sent to you by other health care providers.	
Other:	Include: (Indicate by Initialing)	
Alcohol/Drug Treatment		
Mental Health Information		
Authorization to Discuss Health Information	HIV-Related Information	
(b) D By initialing here I authorize Initials		
to discuss my health information with my attorney, or a gove	rnmental agency, listed here:	
(Attorney/Firm Name or Go	vernmental Agency Name)	
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual	TO A SET SEC.	
☑ Other: Litigation	End of Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
All items on this form have been described and my questions about copy of the form. Signature of patient or representative authorized by law.	this form have been answered. In addition, I have been provided a Date:	

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which crasmally could identify someone as having HIV symptoms or infection and information regarding a person's contacts. Notary Public, State of New York No. 01VE6066189

Maisi Vella

Qualified in Nassau County Commission Expires November 13, 23.



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address	·	
338 Boyle Road, Selden, NY 11784	-	

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 authorization.
- 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 O	R GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).
7. Name and address of health provider or entity to release this infi Miriam Cremer MD, One Gustave L. Levy Place, New	York, New York 10029
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th I	is information will be sent: loor, New York, NY 10038
9(a). Specific information to be released:	
☐ Medical Record from (insert date)	to (insert date)
Entire Medical Record, including patient histories, office n referrals, consults, billing records, insurance records, and in	otes (except psychotherapy notes), test results, radiology studies, films, records sent to you by other health care providers.
☐ Other: Include: (Indicate by Initialing)	
Alcohol/Drug Treatment	
Mental Health Information	
Authorization to Discuss Health Information HIV-Related Information	
(b) ☐ By initialing here I authorize	-
to discuss my health information with my attorney, or a gove	mmental agency, listed here:
(Attorney/Firm Name or Go	vermental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
At request of individual	11. Date of event on winding and asserting the state of t
☑ Other: Litigation	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions about copy of the form.	nt this form have been answered. In addition, I have been provided a

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

Signature of patient or representative authorized by law.

Notary Public, State of New York No. 01VE6066189 Qualified in Nassau County Commission Expires Newsmoot, 13





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

Patient Name Shara DeJesus	Date of Birth 1/15/67	Social Security Number 133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 anthorization 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 authorization.
- 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 CARR WITH ANYONE OTHER THAN THE AUTORNEY OR COVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF	R GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (B).	
7. Name and address of health provider or entity to release this info	rmation:	
John T. Mather Memorial Hospital, 75 N. Country Roa		
 Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F 	is information will be sent: loor, New York, NY 10038	
9(a). Specific information to be released:		
☐ Medical Record from (insert date)	to (insert date) to (except psychotherapy notes), test results, radiology studies, films,	
Entire Medical Record, including patient histories, office no referrals, consults, billing records, insurance records, and re	otes (except psychotherapy notes), test results, radiology studies, films, ecords sent to you by other health care providers.	
Other:	Include: (Indicate by Initialing)	
Alcohol/Drug Treatment		
Mental Health Information		
Authorization to Discuss Health Information HIV-Related Information		
(b) ☐ By initialing here I authorize		
(b) ☐ By initialing here I authorize		
to discuss my health information with my attorney, or a gover	mmental agency, listed here:	
(Attorney/Firm Name or Go	vernmental Agency Name)	
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual	TO T OX P.C. As	
☑ Other: Litigation	End of Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
*(/) /	t this form have been answered. In addition, I have been provided a	
copy of the form.	<u>_</u>	
	Date: 3-12-12	
	Date:	
Signature of patient or representative authorized by law.		

Human Immunodeficiency Virus 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.

Notary Public, State of New York

Mari Vella

No. 01VE6066189

Qualified in Nassau County

Commission Expires November 13,





AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by t	morrow roll bond sopulations	
Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		
I, or my authorized representative, request that health information in accordance with New York State Law and the Privacy Rule of (HIPAA), I understand that: 1. This authorization may include disclosure of information TREATMENT, except psychotherapy notes, and CONFIDEN the appropriate line in Item 9(a). In the event the health information that the line on the box in Item 9(a), I specifically authorize reconstituted from redisclosing such information without my authorizated that I have the right to request a list of people whom I experience discrimination because of the release or disclosure of Human Rights at (212) 480-2493 or the New York City (responsible for protecting my rights. 3. I have the right to revoke this authorization at any time by revoke this authorization except to the extent that action has already in the conditioned upon my authorization of this disconstruction of this disconstruction is conditioned upon my authorization of this disconstruction may no longer be protected by federal or state law. 6. THIS AUTHORIZATION DOES NOT AUTHORIZE Y CARE WITH ANYONE OTHER TBAN THE ATTORNEY. 7. Name and address of health provider or entity to release this Planned Parenthood Hudson Peconic, 4 Skyline Driventer in the provider of the provider of the provider or entity to release this planned Parenthood Hudson Peconic, 4 Skyline Driventer in the provider of the provider of the provider or entity to release this planned Parenthood Hudson Peconic, 4 Skyline Driventer in the provider of the	relating to ALCOHOL and DITIAL HIV* RELATED INFOR- nation described below includes a clease of such information to the p drug treatment, or mental health of HIV-related information, I ma Commission of Human Rights at writing to the health care provide eady been taken based on this auti My treatment, payment, enrollm isclosure. disclosed by the recipient (except OU TO DISCUSS MY HEALT OR GOVERNMENTAL AGE) information:	and Accountability Act of 1996 RUG ABUSE, MENTAL HEALTH MATION only if I place my initials on my of these types of information, and I berson(s) indicated in Item 8. treatment information, the recipient is do so under federal or state law. I d information without authorization. If my contact the New York State Division (212) 306-7450. These agencies are r listed below. I understand that I may horization. ent in a health plan, or eligibility for of as noted above in Item 2), and this
8. Name and address of person(s) or category of person to whon McAloon & Friedman, P.C., 123 William Street, 25th	n this information will be sent:	8
9(a). Specific information to be released:	to (insert date) the notes (except psychotherapy nor not records sent to you by other he	tes), test results, radiology studies, films,
Authorization to Discuss Health Information	·	HIV-Related Information
(b) By initialing here I authorize Initials to discuss my health information with my attorney, or a g	Name of individual health	
	Governmental Agency Name)	
10. Reason for release of information:	11. Date or event on which	this authorization will expire:
☐ At request of individual	End of Litigation	and the state of t
☑ Other: Litigation	13. Authority to sign on bel	half of patient
12. If not the patient, name of person signing form: Robert F. Danzi	Power of Attorney	um or pourous
All items on this form have been completed and my questions a		

Signature of patient or representative authorized by law.

copy of the form.

* Human Immunodeficiency Virus 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.

MARCI VELLA

Notary Public, State of New York

Notary Public, State of New York

No. 01VE8086189

No. 01VE8086189

Qualified in Nassau County

Qualified in Nassau County





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

Patient Name Shara DeJesus	Date of Birth 1/15/67	Social Security Number 133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY U		
7. Name and address of health provider or entity to release this information:		
Evan Gellar MD, 625 Belle Terre Rd., Suite 201, Port Jefferson, NY 11777		
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F	is information will be sent: loor, New York, NY 10038	
9(a). Specific information to be released:		
☐ Medical Record from (insert date)	to (insert date)	
Entire Medical Record, including patient histories, office no referrals, consults, billing records, insurance records, and re	otes (except psychotherapy notes), test results, radiology studies, films,	
☐ Other:	Include: (Indicate by Initialing)	
·	Alcohol/Drug Treatment	
Mental Health Information		
Authorization to Discuss Health Information HIV-Related Information		
(b) ☐ By initialing here I authorize		
Initials	Name of individual health care provider	
to discuss my health information with my attorney, or a govern	mmental agency, listed here:	
(Attorney/Firm Name or Gov		
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual ☐ Other: Litigation	End of Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
/	t this form have been answered. In addition, I have been provided a	
copy of the form. Signature of nations or representative authorized by law	Date: 3-12-12	

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

A Notary Public, State of New York

No. 01VE6066189

Oualified in Nassau County
Commission Expires November 13,



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address	-	
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF	R GOVERNMENTAL AGENCY SPECIFIED IN TIEM 9 (b).	
7. Name and address of health provider or entity to release this info Mobin Sadiq MD, 75 North Country Road, Port Jeffers	on, NY 11777	
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F	is information will be sent: loor, New York, NY 10038	
9(a). Specific information to be released:		
☐ Medical Record from (insert date)	to (insert date)	
Entire Medical Record, including patient histories, office no referrals, consults, billing records, insurance records, and n	ites (except psychotherapy notes), test results, radiology studies, films,	
Other:	Include: (Indicate by Initialing)	
Alcohol/Drug Treatment		
Mental Health Information		
Authorization to Discuss Health Information	HIV-Related Information	
(b) D By initialing here I authorize		
Initials	Name of individual health care provider	
to discuss my health information with my attorney, or a gover	nmental agency, listed here:	
(Attorney/Firm Name or Gov	vernmental Agency Name)	
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual		
☑ Other: Litigation	End of Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
All items on this form have been completed and my questions about copy of the form. Signature of patient or representative authorized by law.	this form have been answered. In addition, I have been provided a Date:	

* Human Immunodeficiency Virus 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.

MARCIVELIA

MARCIVELIA

Contact of New York

MaieVella

Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires Nevember 18, 20



Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784	· · · · · · · · · · · · · · · · · · ·	
, or my authorized representative, request that health informat	ion regarding my care and treatmen	nt be released as set forth on this form:
n accordance with New York State Law and the Privacy Rule	of the Health Insurance Portability	and Accountability Act of 1996
HIPAA). I understand that:		•
I. This authorization may include disclosure of information ITREATMENT, except psychotherapy notes, and CONFIDER	n relating to ALCOHOL and DI	MATION only if I blace my initials or
he appropriate line in Item 9(a). In the event the health infor	mation described below includes a	ny of these types of information, and
nitial the line on the box in Item 9(a). I specifically authorize t	release of such information to the p	erson(s) indicated in Item 8.
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 tederal or state law.
inderstand that I have the right to request a list of people who experience discrimination because of the release or disclosur	may receive or use my HIV-related information. I ma	by 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
esponsible for protecting my rights.		
3. I have the right to revoke this authorization at any time by	writing to the health care provide	r listed below. I understand that I may
evoke this authorization except to the extent that action has al	ready been taken based on this auti	horrzation. ont in a health plan, or eligibility fo
I understand that signing this authorization is voluntary, benefits will not be conditioned upon my authorization of this	. My treatment, payment, emonio disclosure	the in a meanin plan, or originally to
5. Information disclosed under this authorization might be r	redisclosed by the recipient (excep	ot as noted above in Item 2), and thi
edisclosure may no longer be protected by federal or state law.	· •	·
C. PONTO A TERRITORIZATIONI POPE NOT ATITUODIZE	VALUE OF DISCUSS MY OF ALT	PU INDODMATION OD MICHEAU
6. THIS AUTHORIZATION DOES NOT AUTHORIZE	TOU TO DESCUSSIVE MEANI	MANAGEMENT OF THE MOON OF THE
CARE WITH ANYONE OTHER THAN THE ATTORNE	Y OR GOVERNMENTAL AGE	NCY SPECIFIED IN ITEM 9 (b).
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7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers. R. Name and address of person(s) or category of person to who	Y OR GOVERNMENTAL AGES s information: son, NY 11777 om this information will be sent:	NCY SPECIFIED IN ITEM 9 (b).
CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers 8. Name and address of person(s) or category of person to who McAloon & Friedman, P.C., 123 William Street, 25	Y OR GOVERNMENTAL AGES s information: son, NY 11777 om this information will be sent:	NCY SPECIFIED IN ITEM 9 (b).
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CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers 8. Name and address of person(s) or category of person to who McAloon & Friedman, P.C., 123 William Street, 25 9(a). Specific information to be released: 12 Medical Record from (insert date) 13 Entire Medical Record, including patient histories, office	Y OR GOVERNMENTAL AGES s information: son, NY 11777 om this information will be sent: ith Floor, New York, NY 1003	8 tes), test results, radiology studies, film
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CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers 8. Name and address of person(s) or category of person to who McAloon & Friedman, P.C., 123 William Street, 25 9(a). Specific information to be released: ☐ Medical Record from (insert date) ☐ Entire Medical Record, including patient histories, off referrals, consults, billing records, insurance records, ☐ Other: Authorization to Discuss Health Information	Y OR GOVERNMENTAL AGE s information: son, NY 11777 om this information will be sent: ith Floor, New York, NY 1003 to (insert date) ice notes (except psychotherapy no and records sent to you by other he Include:	tes), test results, radiology studies, film alth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information
CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers 8. Name and address of person(s) or category of person to who McAloon & Friedman, P.C., 123 William Street, 25 9(a). Specific information to be released: 1 Medical Record from (insert date) 2 Entire Medical Record, including patient histories, offi referrals, consults, billing records, insurance records, 1 Other: Authorization to Discuss Health Information (b) By initialing here I authorize Initials	Y OR GOVERNMENTAL AGE s information: son, NY 11777 on this information will be sent: ith Floor, New York, NY 1003 to (insert date) ice notes (except psychotherapy no and records sent to you by other he Include: Name of individual healt	tes), test results, radiology studies, film alth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information
CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers 8. Name and address of person(s) or category of person to who McAloon & Friedman, P.C., 123 William Street, 25 9(a). Specific information to be released: Medical Record from (insert date) Entire Medical Record, including patient histories, off referrals, consults, billing records, insurance records, Other: Other: Authorization to Discuss Health Information (b) By initialing here I authorize	Y OR GOVERNMENTAL AGE s information: son, NY 11777 on this information will be sent: ith Floor, New York, NY 1003 to (insert date) ice notes (except psychotherapy no and records sent to you by other he Include: Name of individual healt	tes), test results, radiology studies, film alth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information
CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers 8. Name and address of person(s) or category of person to who McAloon & Friedman, P.C., 123 William Street, 25 9(a). Specific information to be released:	Y OR GOVERNMENTAL AGES s information: son, NY 11777 om this information will be sent: ith Floor, New York, NY 1003	8 tes), test results, radiology studies, film alth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HTV-Related Information
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Authorization to Discuss Health Information (b) □ By initialing here I authorize I authorize I authorize I attorney/Firm Name of O. Reason for release of information: □ At request of individual	Y OR GOVERNMENTAL AGE s information: son, NY 11777 om this information will be sent: ith Floor, New York, NY 1003	8 tes), test results, radiology studies, film alth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HTV-Related Information
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CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this Robert Derman MD, 33 Landing Lane, Port Jeffers 8. Name and address of person(s) or category of person to who McAloon & Friedman, P.C., 123 William Street, 25 9(a). Specific information to be released: Medical Record from (insert date) Entire Medical Record, including patient histories, off referrals, consults, billing records, insurance records, other: Other:	Y OR GOVERNMENTAL AGE s information: son, NY 11777 om this information will be sent: ith Floor, New York, NY 1003	8. tes), test results, radiology studies, film alth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information h care provider this authorization will expire:

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus 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.

MariaVella

Date:

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County



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

Patient Name	Date of Birth	Social Security Number
Shara De Jesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF	R GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (D).
7. Name and address of health provider or entity to release this info	
Queens Long Island Med Group, 640 Hawkins Ave., Ro	
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F.	is information will be sent: loor, New York, NY 10038
9(a). Specific information to be released:	
☐ Medical Record from (insert date)	to (insert date)
Entire Medical Record, including patient histories, office no	otes (except psychotherapy notes), test results, radiology studies, films,
referrals, consults, billing records, insurance records, and r	ecords sent to you by other health care providers.
Other:	Include: (Indicate by Initialing)
·	Alcohol/Drug Treatment
	Mental Health Information
Authorization to Discuss Health Information	HIV-Related Information
(b) □ By initialing here I authorize	
(b) ☐ By initialing here I authorize	Name of individual health care provider
to discuss my health information with my attorney, or a govern	mmental agency, listed here:
(Attorney/Firm Name or Go	vernmental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual	
Other: Litigation	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions about	t this form have been answered. In addition, I have been provided a
copy of the form.	Date: $3 - 12 - 12$
Signature of patient or representative authorized by law.	

Human Immunodeficiency Virus 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.

MARCI VELLA

Notation Public State of New York Contacts.

Marci Vella

Notary Public, State of New York No. 01VE6066189 Qualified in Nassau County Commission Expires Nexember 13, 2



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY O	R GOVERNMENTAL AGENCY SPECIFIED IN HEMY (D).
7. Name and address of health provider or entity to release this inf Michael Aian Lee MD, 640 Hawkins Ave., Ronkonkon	
8. Name and address of person(s) or category of person to whom t McAloon & Friedman, P.C., 123 William Street, 25th I	ils information will be sent: Floor, New York, NY 10038
9(a). Specific information to be released:	
☐ Medical Record from (insert date)	to (insert date)
Entire Medical Record, including patient histories, office r referrals, consults, billing records, insurance records, and	totes (except psychotherapy notes), test results, radiology studies, films,
Other:	Include: (Indicate by Initialing)
	Alcohol/Drug Treatment
	Mental Health Information
Authorization to Discuss Health Information	HIV-Related Information
(b) ☐ By initialing here I authorize	
Initials	Name of individual health care provider
to discuss my health information with my attorney, or a gove	emmental agency, listed here:
(Attorney/Firm Name or Go	overnmental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual	
☑ Other: Litigation	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions about copy of the form. Signature of patient or representative authorized by law.	Date:
Signature of patient of representative authorized by law.	

* Human Immunodeficiency Virus 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.

busi VIlla

Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires Nevember 13, 20



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

Patient Name Shara DeJesus	Date of Birth 1/15/67	Social Security Number 133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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:

- I. 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 authorization.
- 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 CAPE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

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 Bhanumathy Vinayagasundaram MD, 640 Hawkins	information: Ave., Ronkonkoma, NY 11779
8. Name and address of person(s) or category of person to whom McAloon & Friedman, P.C., 123 William Street, 25th	n this information will be sent; h Floor, New York, NY 10038
9(a). Specific information to be released:	
☐ Medical Record from (insert date)	to (insert date)
Entire Medical Record, including patient histories, offic referrals, consults, billing records, insurance records, ar	e notes (except psychotherapy notes), test results, radiology studies, films, and records sent to you by other health care providers.
Other:	Include: (Indicate by Initialing)
	Alcohol/Drug Treatment
	Mental Health Information
Authorization to Discuss Health Information	HIV-Related Information
	- The state of the
(b) ☐ By initialing here I authorize	Name of individual health care provider
Initials	
to discuss my health information with my attorney, or a go	overnmental agency, usled here:
(Attorney/Firm Name or	Governmental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual	
☑ Other: Litigation	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions a	bout this form have been answered. In addition, I have been provided a
copy of the form.	
IV	2 12 13

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus 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.

Notary Public. State of New York

Notary Public, No. 011 No. 011 Qualified in

No. 01VE6066189

Qualified in Nassau County
Commission Expires November 18, 20



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF	
7. Name and address of health provider or entity to release this info	imation:
Dana Brenner MD, 200 Belle Terre Rd., Port Jefferson,	
8. Name and address of person(s) or category of person to whom the	s information will be sent:
McAloon & Friedman, P.C., 123 William Street, 25th F	loor, New York, NY 10038
9(a). Specific information to be released:	•
☐ Medical Record from (insert date)	to (insert date)
☐ Entire Medical Record, including patient histories, office no	tes (except psychotherapy notes), test results, radiology studies, films,
referrals, consults, billing records, insurance records, and n	ecords sent to you by other health care providers.
Other:	Include: (Indicate by Initialing)
<u> </u>	Alcohol/Drug Treatment
·	Mental Health Information
Authorization to Discuss Health Information	HIV-Related Information
60	(
(b) ☐ By initialing here I authorize	Name of individual health care provider
to discuss my health information with my attorney, or a gover	
to disouss my mountain mediation vital my disoundry, or a govern	
(Attorney/Firm Name or Gov	vernmental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual	
☑ Other: Litigation	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions abou	t this form have been answered. In addition, I have been provided a
copy of the form.	
	7 17 17
()/	Date: 3-1d-1d

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

Signature of patient or representative authorized by law.

Qualified in Nassau County

Commission Expires Nevember 13, 20





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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF	
7. Name and address of health provider or entity to release this info Yanira Raza MD, 6080 Jericho Tnpk., Suite 205, Comm	rmation: ack, NY 11725
8. Name and address of person(s) or category of person to whom this McAloon & Friedman, P.C., 123 William Street, 25th Fl	s information will be sent:
9(a). Specific information to be released:	
Medical Record from (insert date)	o (insert date)
☑ Entire Medical Record, including patient histories, office no	ites (except psychotherapy notes), test results, radiology studies, films,
referrals, consults, billing records, insurance records, and re	ecords sent to you by other health care providers.
Other:	Include: (Indicate by Initialing)
	Alcohol/Drug Treatment
	Mental Health Information
Authorization to Discuss Health Information	HIV-Related Information
(b) [] By initialing here Lauthorize	
(b) ☐ By initialing here I authorize	Name of individual health care provider
to discuss my health information with my attorney, or a gover	
(Attorney/Firm Name or Gov	remmental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual	End of Litigation
☑ Other: Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions abou	t this form have been answered. In addition, I have been provided a
copy of the form.	
	5 1/ 1/
N	Date: 3-12-12
Signature of patient or representative authorized by law.	

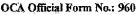
* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

MARC! VELLA

Mari Vella

Netary Public, State of New York
No. 01VE0066189

Qualified in Nassau County
Commission Expires Neventor 18, 2





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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY O	R GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).	
7. Name and address of health provider or entity to release this in Elizabeth Jeremias MD, 300 Bay Shore Rd., N. Babylo	n, NY 11703	
8. Name and address of person(s) or category of person to whom to McAloon & Friedman, P.C., 123 William Street, 25th	his information will be sent: Floor, New York, NY 10038	
9(a). Specific information to be released:		
☐ Medical Record from (insert date)	to (insert date)	
☑ Entire Medical Record, including patient histories, office referrals, consults, billing records, insurance records, and	notes (except psychotherapy notes), test results, radiology studies, films, records sent to you by other health care providers.	
☐ Other:	Include: (Indicate by Initialing)	
	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information HIV-Related Information		
(b) By initialing here I authorize		
(b) D By initialing here I authorize Name of individual health care provider		
to discuss my health information with my attorney, or a gov		
(Attorney/Firm Name or G		
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual		
☑ Other: Litigation	End of Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
copy of the form.	ut this form have been answered. In addition, I have been provided a Date: 3-12-18	
Signature of patient or representative authorized by law.	•	

* Human Immunodeficiency Virus 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.

MARCI VELLA

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires Newspire, 19, 2



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		-

In accordance with New York State Law and the Privacy Rule of the Health Insurance Pol (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 authorization.
- 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 OF	GOVERNMENTAL AGENCY SPECIFIED IN TIEM 9 (D).	
7. Name and address of health provider or entity to release this information: Dr. Palivan, 640 Hawkins Rd., Ronkonkoma, NY 11779		
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th Fl	s information will be sent: loor, New York, NY 10038	
9(a). Specific information to be released: ☐ Medical Record from (insert date)	o (insert date)	
Entire Medical Record, including patient histories, office no referrals, consults, billing records, insurance records, and re	otes (except psychotherapy notes), test results, radiology studies, nims,	
☐ Other: Include: (Indicate by Initialing)		
	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information	HIV-Related Information	
(b) By initialing here I authorize	Name of individual health care provider	
to discuss my health information with my attorney, or a gover		
· ·		
(Attorney/Firm Name or Gov	vernmental Agency Name)	
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual	End of Litigation	
Other: Litigation		
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
All items on this form have been completed and my questions about copy of the form.	t this form have been answered. In addition, I have been provided a	

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could Notary Public, State of New York identify someone as having HIV symptoms or infection and information regarding a person's contacts. No. 01VE6066189

Signature of patient or representative authorized by law.

Qualified in Nassau County Commission Expires Nevember

-LC-



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANTONE OTHER THAN THE ATTORN	ET OR GOVERNMENTAL AGENCY STECTIED IN THEM >(U).	
7. Name and address of health provider or entity to release this information: Richard Rose MD, 300 Atlantic Ave., Greenport, NY 11944		
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, 2	25th Floor, New York, NY 10038	
9(a). Specific information to be released:		
☐ Medical Record from (insert date)	to (insert date)	
	ffice notes (except psychotherapy notes), test results, radiology studies, films, s, and records sent to you by other health care providers.	
☐ Other: Include: (Indicate by Initialing)		
	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information	HIV-Related Information	
(b) D By initialing here I authorize		
Initials Name of individual health care provider		
to discuss my health information with my attorney, or a	a governmental agency, listed here:	
(Attorney/Firm Name	e or Governmental Agency Name)	
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual		
☑ Other: Litigation	End of Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
	s about this form have been answered. In addition, I have been provided a	
copy of the form.		
IV	2 10 10	
	Date:	
Signature of patient or representative authorized by law.	·	

* Human Immunodeficiency Virus 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.

MARCI VELLA

MAHCI VELLA
Notary Püblic, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 13, 2



JUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

L.			
Patient Name		Date of Birth	Social Security Number
Shara DeJesus	-	1/15/67	133-66-9924
Patient Address		,	
338 Boyle Road, Selden	, NY 11784		
			- 4 4 .0 0 0 0 0

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 authorization.
- 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	DR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).	
7. Name and address of health provider or entity to release this information: Stanley Ostrow MD, 285 Sills Rd., East Patchogue, NY 11772		
8. Name and address of person(s) or category of person to whom McAloon & Friedman, P.C., 123 William Street, 25th	this information will be sent: Floor, New York, NY 10038	
9(a). Specific information to be released:	· · · · · · · · · · · · · · · · · · ·	
☐ Medical Record from (insert date)	to (insert date)	
Entire Medical Record, including patient histories, office referrals, consults, billing records, insurance records, and	notes (except psychomerapy notes), test results, radiology studies, mins, records sent to you by other health care providers.	
Other:	Include: (Indicate by Initialing)	
	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information	HIV-Related Information	
(b) ☐ By initialing here I authorize		
Initials	Name of individual health care provider	
to discuss my health information with my attorney, or a go	vernmental agency, listed here:	
	iovernmental Agency Name) 11. Date or event on which this authorization will expire:	
10. Reason for release of information:	11. Date or event on which this authorization will expire.	
☐ At request of individual	End of Litigation	
☑ Other: Litigation		
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
All items on this form have been connected and my questions ab copy of the form.	out this form have been answered. In addition, I have been provided a	

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

Signature of patient or representative authorized by law.

Notary Public, State of New York No. 01VE6066189 Qualified in Nassau County Commission Expires November



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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.
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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 authorization.
- 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 OF	
7. Name and address of health provider or entity to release this info	mation:
Donald Phillibert MD, 1901 1st Avenue, NY, NY 10029	
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F	is information will be sent: loor, New York, NY 10038
9(a). Specific information to be released:	
☐ Medical Record from (insert date)	to (insert date)
☑ Entire Medical Record, including patient histories, office no	otes (except psychotherapy notes), test results, radiology studies, films,
referrals, consults, billing records, insurance records, and r	ecords sent to you by other health care providers.
☐ Other:	Include: (Indicate by Initialing)
	Alcohol/Drug Treatment
	Mental Health Information
Authorization to Discuss Health Information	HIV-Related Information
(b) D By initialing here Initials	Name of individual health care provider
Initials Name of individual nealth care provider to discuss my health information with my attorney, or a governmental agency, listed here:	
to discuss my heard information with my attorney, or a gove	initialitat agoney, iistori itero.
(Attorney/Firm Name or Go	vernmental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual	
☑ Other: Litigation	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions abou	t this form have been answered. In addition, I have been provided a
copy of the form.	
	2 12 12
	Date: $3 - 12 - 12$
Signature of patient or representative authorized by law.	

Human Immunodeficiency Virus 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. MARCI VELLA

MarsVella

Notary Public, State of New York No. 01VE6066189 Qualified in Nassau County Commission Expires Neverriber



AUTHORIZATION FOR RELEASE OF HEA [This form has been approved by the	ALTH INFORMATION PURSU • New York State Department of Hea	IANT TU HIPAA	
Patient Name	Date of Birth	Social Security Number	
Shara DeJesus	1/15/67	133-66-9924	
Patient Address		<u>. L </u>	
338 Boyle Road, Selden, NY 11784		·	
I, or my authorized representative, request that health information	regarding my care and treatment be re	leased as set forth on this fo	ım:
In accordance with New York State Law and the Privacy Rule of the (HIPAA), I understand that: 1. This authorization may include disclosure of information retreatment, except psychotherapy notes, and CONFIDENTA the appropriate line in Item 9(a). In the event the health informationitial the line on the box in Item 9(a), I specifically authorize relected. If I am authorizing the release of HIV-related, alcohol or draprohibited from redisclosing such information without my authorizerand that I have the right to request a list of people who may be experience discrimination because of the release or disclosure of the Human Rights at (212) 480-2493 or the New York City Corresponsible for protecting my rights. 3. I have the right to revoke this authorization at any time by we revoke this authorization except to the extent that action has alreaded. I understand that signing this authorization is voluntary. Menefits will not be conditioned upon my authorization of this disconsistency of the conditioned upon my authorization of this disconsistency. Information disclosed under this authorization might be redisclosure may no longer be protected by federal or state law. 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU CARE WITH ANYONE OTHER THAN THE ATTORNEY CONTENTS.	elating to ALCOHOL and DRUG AL HIV* RELATED INFORMATI- tion described below includes any of tase of such information to the person(sing freatment, or mental health treatmentization unless permitted to do so y receive or use my HIV-related information, I may contimulate to the health care provider listed dy been taken based on this authorization treatment, payment, enrollment in closure. Sclosed by the recipient (except as not the person of the p	ABUSE, MENTAL HEAL ON only if I place my initial hese types of information, a s) indicated in Item 8. ent information, the recipier under federal or state law mation without authorization act the New York State Divi 306-7450. These agencies below. I understand that I ion, a health plan, or eligibility oted above in Item 2), and FORMATION OR MEDIC	LTH ls on and I ant is w. I n. If ision s are may y for this
7. Name and address of health provider or entity to release this in Stony Brook Univ. Hospital, 100 Nicolls Road, Stony F	formation:		
8. Name and address of person(s) or category of person to whom t			
McAloon & Friedman, P.C., 123 William Street, 25th	Floor, New York, NY 10038		
9(a). Specific information to be released: ☐ Medical Record from (insert date) ☐ Entire Medical Record, including patient histories, office referrals, consults, billing records, insurance records, and	to (insert date) notes (except psychotherapy notes), te records sent to you by other health ca	st results, radiology studies, re providers. te by Initialing)	films,
Other:	•	hol/Drug Treatment	
Mental Health Information			
Authorization to Discuss Health Information	HIV	-Related Information	
(b) ☐ By initialing here I authorize		······································	_
Initials to discuss my health information with my attorney, or a gov	Name of individual health care pernmental agency, listed here:	novid er	•
(Attorney/Firm Name or G	overnmental Agency Name)		
10. Reason for release of information:	11. Date or event on which this ar	nthorization will expire:	
☐ At request of individual	End of Litigation		
Other: Litigation	End of Litigation	-atianti	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of	patient:	

copy of the form.

Signature of patient or representative authorized by law.

Robert F. Danzi

Human Immunodeficiency Virus 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. Naie VU

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

Power of Attorney

MARCI VELLA Notary Public, State of New Yor No. 01VE6066189 Qualified in Nassau County



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

Patient Name Shara DeJesus	Date of Birth 1/15/67	Social Security Number 133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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 OF	R GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).
7. Name and address of health provider or entity to release this info HIP Pharmacy, 640 Hawkins Ave., Ronkonkoma 11779	
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F	is information will be sent: loor, New York, NY 10038
9(a). Specific information to be released:	
☐ Medical Record from (insert date)	to (insert date)
☑ Entire Medical Record, including patient histories, office n	otes (except psychotherapy notes), test results, radiology studies, films,
referrals, consults, billing records, insurance records, and r	ecords sent to you by other health care providers.
Other:	Include: (Indicate by Initialing)
	Alcohol/Drug Treatment
	Mental Health Information
Authorization to Discuss Health Information	HIV-Related Information
(b) ☐ By initialing here I authorize	
Initials	Name of individual health care provider
to discuss my health information with my attorney, or a gove	rnmental agency, listed here:
(Attorney/Firm Name or Go	vernmental Agency Name)
10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual	77 N. CT 1/1 . / 1
Other: Litigation	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Robert F. Danzi	Power of Attorney
All items on this form have been completed and my questions about	nt this form have been answered. In addition, I have been provided a
copy of the form.	
	2 17 17
	Date: 0-12-10
Signature of patient or representative authorized by law.	

Human Immunodeficiency Virus 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.

NawVilla

MARCI VELLA Notary Public, State of New Yor No. 01VE6066189 Qualified in Nassau County



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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

	OR GOVERNMENTAL AGENCY SPECIFIED IN LIEM 9 (B).		
7. Name and address of health provider or entity to release this in	formation:		
Medical Group Pharmacy, 650 Hawkins Ave., Ronko			
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 Record from (insert date)	_ to (insert date)		
☑ Entire Medical Record, including patient histories, office	notes (except psychotherapy notes), test results, radiology studies, films,		
referrals, consults, billing records, insurance records, and			
Other:	Inchaile: (Indicate by Initialing)		
	Alcohol/Drug Treatment		
	Mental Health Information		
tust minitial to Diagram Worldh Juformation	HIV-Related Information		
Authorization to Discuss Health Information			
(b) ☐ By initialing here I authorize			
to discuss my health information with my attorney, or a gov	ernmental agency, listed here:		
(Au	Sovernmental Agency Name)		
	11. Date or event on which this authorization will expire:		
10. Reason for release of information:	11. Date of event on which this authorization will expire.		
☐ At request of individual ☐ Other: Litigation	End of Litigation		
	13. Authority to sign on behalf of patient:		
12. If not the patient, name of person signing form:	Power of Attorney		
Robert F. Danzi			
	out this form have been answered. In addition, I have been provided a		
copy of the form.	•		
111	2 11 11		
	Date: 3-12-12		
Signature of patient of representative authorized by law.			

Human Immunodeficiency Virus 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.

MARCI VELLA

Mais Vella

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
County Resion Expires November 13, 2



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

Patient Name	Date of Birth	Social Security Number
Shara DeJesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF			
7. Name and address of health provider or entity to release this info	rmation:		
Prescription Den Pharmacy, 239 Boyle Rd., Selden, NY	11784		
8. Name and address of person(s) or category of person to whom th	is information will be sent:		
McAloon & Friedman, P.C., 123 William Street, 25th F	loor, New York, NY 10038		
9(a). Specific information to be released:			
☐ Medical Record from (insert date)	to (insert date)		
☑ Entire Medical Record, including patient histories, office no	tes (except psychotherapy notes), test results, radiology studies, films,		
referrals, consults, billing records, insurance records, and r	ecords sent to you by other health care providers.		
☐ Other:	Include: (Indicate by Initialing)		
	Alcohol/Drug Treatment		
	Mental Health Information		
A CONTROL OF THE STATE OF THE S	HIV-Related Information		
Authorization to Discuss Health Information	HIV-Related information		
(b) ☐ By initialing here I authorize			
to discuss my health information with my attorney, or a governmental agency, listed here:			
(Attorney/Firm Name or Gov			
10. Reason for release of information:	11. Date or event on which this authorization will expire:		
At request of individual	End of Litigation		
☑ Other: Litigation			
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:		
Robert F. Danzi	Power of Attorney		
All items on this form have been completed and my questions about	t this form have been answered. In addition, I have been provided a		
copy of the form.			
	2 12 12		
\mathbb{Q}^{p}	Date: 5-12-10		
Signature of patient or representative authorized by law.			

* Human Immunodeficiency Virus 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.

Notary Public, State of New York

No. 01VE6066189

Qualified in Nassau County

Commission Expires Nevember 13, 29





AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

Patient Name	Date of Birth	Social Security Number
Shara De Jesus	1/15/67	133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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).

	OR GUVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (D).		
7. Name and address of health provider or entity to release this information: Stony Brook Univ. Hospital, 101 Nicolls Road, Stony Brook, NY 11790			
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 Record from (insert date)	to (insert date)		
☐ Medical Record from (insert date)			
☑ Other: Employment records	Include: (Indicate by Initialing)		
	Alcohol/Drug Treatment		
	Mental Health Information		
Authorization to Discuss Health Information	HIV-Related Information		
(b) D By initialing here I authorize			
to discuss my health information with my attorney, or a gov	ernmental agency, listed here:		
(Attorney/Firm Name or G	overnmental Agency Name)		
10. Reason for release of information:	11. Date or event on which this authorization will expire:		
☐ At request of individual			
Other, Litigation	End of Litigation		
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:		
Robert F. Danzi	Power of Attorney		
copy of the form.	ut this form have been answered. In addition, I have been provided a Date: 3-13-13		
Signature of patient or representative authorized by law.	÷		

* Human Immunodeficiency Virus 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. MARC! VELLA

Marci Vella

Notary Public, State of New York No. 01VE6066189 Qualified in Nassau County Commission Expires November 13, 20



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

Patient Name Shara DeJesus	Date of Birth 1/15/67	Social Security Number 133-66-9924
Patient Address		
338 Boyle Road, Selden, NY 11784		

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 authorization.
- 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 CAPE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF	GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).	
 Name and address of health provider or entity to release this info Medicaid, 222 Church Street, NY, NY 10008 	rmation:	
8. Name and address of person(s) or category of person to whom thi McAloon & Friedman, P.C., 123 William Street, 25th Fl	s information will be sent: oor, New York, NY 10038	
referrals, consults, billing records, insurance records, and re	ntes (except psychotherapy notes), test results, radiology studies, innis, ecords sent to you by other health care providers.	
Other: BZ41670G Include: (Indicate by Initialing)		
Authorization to Discuss Health Information	Alcohol/Drug TreatmentMental Health InformationHIV-Related Information	
(b) D By initialing here I authorize Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here:		
(Attorney/Firm Name or Gov	remmental Agency Name)	
10. Reason for release of information: ☐ At request of individual ☐ Other: Litigation	11. Date or event on which this authorization will expire: End of Litigation	
12. If not the patient, name of person signing form: Robert F. Danzi	13. Authority to sign on behalf of patient: Power of Attorney	
All items on this form have been completed and my questions about copy of the form.	this form have been answered. In addition, I have been provided a Date: 3 - 12 - 12	

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which response with the second of the State Public, State State Public, State S

Mai Illa

Commission Expires November 19,



Patient Name	Date of Birth	Social Security Number
Shara De Jesus	1/15/67	133-66-9924
Patient Address		•
338 Boyle Road, Selden, NY 11784		
, or my authorized representative, request that	health information regarding my care and treatme	nt be released as set forth on this fo
	e Privacy Rule of the Health Insurance Portability	
HIPAA). I understand that:		
. This authorization may include disclosure	of information relating to ALCOHOL and D	RUG ABUSE, MENTAL HEAL
FREATMENT, except psychotherapy notes, a	nd CONFIDENTIAL HIV* RELATED INFOR	MATION only if I place my initial
he appropriate line in Item 9(a). In the event	the health information described below includes a	any of these types of information, a
mitial the line on the how in Item O(a) I enecifi	cally 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 authorization.
- 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 OF	R GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).	
7. Name and address of health provider or entity to release this info HIP, 55 Water Street, NY, NY 10041-8190	rmation:	
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street, 25th F	is information will be sent: loor, New York, NY 10038	
9(a). Specific information to be released:		
Medical Record from (insert date)	to (insert date)	
☐ Entire Medical Record, including patient histories, office n	otes (except psychotherapy notes), test results, radiology studies, films,	
referrals, consults, billing records, insurance records, and a	ecords sent to you by other health care providers.	
☑ Other: Insurance records	Include: (Indicate by Initialing)	
ID # 15601311	Alcohol/Drug Treatment	
Mental Health Information		
Andread to Divine Wealth Information	HIV-Related Information	
(b) ☐ By initialing here I authorize		
(b) ☐ By initialing here I authorize Name of individual health care provider		
to discuss my health information with my attorney, or a governmental agency, listed here:		
(Attorney/Firm Name or Governmental Agency Name)		
	11. Date or event on which this authorization will expire:	
10. Reason for release of information:	11. Date of event on which this memorization will explicit	
☐ At request of individual ☐ Other: Litigation	End of Litigation	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
Robert F. Danzi	Power of Attorney	
	t this form have been answered. In addition, I have been provided a	
copy of the form.	- · ·	
11 1/	Date: 3-12-13	
	Date: 3 10 10	
Signature of patient or representative authorized by law.		

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

Notary Public, State of New York No. 01VE6066189 Qualified in Nassau County Commission Expires Nevember

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION (UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW)

THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL OR OTHER HEALTH CARE DECISIONS

This is intended to constitute a DURABLE POWER OF ATTORNEY to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Shara DeJesus residing at 338 Boyle Road, Selden, New York 11784

do hereby appoint my attorney:

Law Office of Robert F. Danzi

900 Merchants Concourse, Suite 314

Westbury, New York 11590

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

THIS DURABLE POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OF INCOMPETENCE.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OF 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 MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

In Witness Whereof I have hereunto signed my name this Haday of Myth, 2011.

Shara DeJesus

Shara DeJesus

State of New York

) ss.:

On the day of word, 201, before me, the undersigned, a Notary Public in and for said State, personally appeared Shara DeJesus, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

MARCI VELLA Notary Public, State of New York No. 01VE30F3189

Outlified in Nassau County
Commission Expires Navember 12.

Notary Public

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

Mary Braymann, being sworn, says:

I am not a party to the action, am over 18 years of age and reside at Central Islip, New York.

On March 12, 2012 I served the within

PLAINTIFF'S RESPONSE TO COMBINED DEMANDS

by depositing a true copy thereof enclosed in a post-paid wrapper, in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State, addressed to each of the following persons at the last known address set forth herein, as follows:

FUMUSO, KELLY, DeVERNA, SNYDER, SWART & FARRELL, LLP Attorneys for Defendant JOHN T. MATHER MEMORIAL HOSPITAL 110 Marcus Blvd. Hauppauge, NY 11788 (631) 232-0200

SILVERSON, PARERES & LOMBARDI, LLP Attorneys for Defendants QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., and BHANUMATHY VINAYAGASUNDARAM, M.D., 192 Lexington Avenue, 17th Floor New York, NY 10016 (212) 557-1810

McALOON & FRIEDMAN, P.C. Attorneys for Defendant PLANNED PARENTHOOD HUDSON PECONIC, INC. 123 William Street, 25th Floor New York, NY 10038 (212) 732-8700

KAUFMAN, BORGEEST & RYAN, LLP Attorneys for Defendant THE MOUNT SINAI HOSPITAL 120 Broadway, 14th Floor New York, New York 10271 (212) 980-9600

Sworn to before me this lay of March, 2012

Public

MARCI VELLA Notary Public, State of New York No. 01VE6066189 Qualified in Nassau County

Commission Expires Noven

Mary Bra

INDEX NO.: 150347/11

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF SUFFOLK

SHARA DEJESUS.

Plaintiff,

- against

PLANNED PARENTHOOD HUDSON PECONIC, INC., "JOHN DOE", M.D., QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D., BHANUMATHY VINAYAGASUNDARAM, M.D., JOHN T. MATHER MEMORIAL HOSPITAL, THE MOUNT SINAI HOSPITAL and MIRIAM CREMER, M.D.,

Defendants.

PLAINTIFF'S RESPONSE TO COMBINED DEMANDS

Law Office of Robert F. Danzi
Attorney for Plaintiff
900 Merchants Concourse, Suite 314
Westbury, New York 11590
T: (516) 228-4226
F: (516) 228-6569