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:

1. 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*;
- 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.

All injuries 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.

c) Plaintiff, SHARA DEJESUS, was confined to her bed for approximately two months.

10. 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.

12. 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.

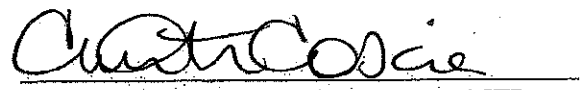
17. See paragraph "16" above.

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
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900 Merchants Concourse, Suite 314
Westbury, New York 11590
(516) 228-4226

TO: SILVERSON, PARERES & LOMBARDI, LLP
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(212) 557-1818

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(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

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
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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.,
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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
19th day of March, 2012

Notary Public

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 13, 20__
1/8/14

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
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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, 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 genito-urniary 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:

- 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.

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.

c) 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
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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

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
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QUEENS LONG ISLAND MEDICAL GROUP, P.C., MICHAEL ALAN LEE, M.D.,
and BHANUMATHY VINAYAGASUNDARAM, M.D.,
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KAUFMAN, BORGEEST & RYAN, LLP
Attorneys for Defendant
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120 Broadway, 14th Floor
New York, New York 10271
(212) 980-9600

Kathleen Chiddo
Kathleen Chiddo

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

Marci Vella
Notary Public

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires ~~November 13, 20__~~
1/18/14

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

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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.

----------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, THE MOUNT SINAI HOSPITAL sets forth as follows:

1. 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.

c) 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.

12. 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

Kathleen Chiddo

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

Notary Public

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 13, 20~~14~~ 18

1/18/14

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

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, MIRIAM CREMER, M.D. sets forth as follows:

1. 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*

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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.

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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,

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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;
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- emotional pain;
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- 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.

c) 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.

12. 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
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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.,
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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 13, 20

1/18/14

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

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

----------X

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.

----------X

Index No.: 150347/11

PLAINTIFF'S RESPONSE TO COMBINED DEMANDS

Plaintiff, SHARA DEJESUS, by her attorney, the LAW OFFICE OF ROBERT F. DANZI, for her Response to Demands of defendant, PLANNED PARENTHOOD HUDSON PECONIC, INC., set forth as follows:

DEMAND FOR AUTHORIZATIONS

Enclosed are the following authorizations:

- The Mount Sinai Hospital
- Miriam Cremer MD
- 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.

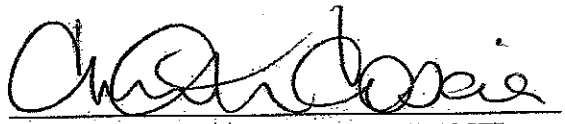
4. Upon information and belief, BZ41670G.

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
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 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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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 this form have been answered. In addition, I have been provided a copy of the form.

Date: 3-12-10

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 November 13, 20__

Maria Vella

1-12-10

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
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 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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

OCA Official Form No.: 960

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.
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5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
John T. Mather Memorial Hospital, 75 N. Country Road, Port Jefferson, NY 11777

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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 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

MARCI VELLA
Notary Public, State of New York
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Patient Name	Date of Birth	Social Security Number
Shara DeJesus	**1/15/67**	**133-66-9924**
Patient Address: **338 Boyle Road, Selden, NY 11784**		

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7. Name and address of health provider or entity to release this information:
Planned Parenthood Hudson Peconic, 4 Skyline Drive, Hawthorne, NY 10532

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) _____
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Authorization to Discuss Health Information

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10. Reason for release of information:	11. Date or event on which this authorization will expire:
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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 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
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 13, 20

Marci Vella

OCA Official Form No.: 960

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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
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 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 records sent to you by other health care providers.
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Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

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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 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.**

Mari Vella

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

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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Patient Name	Date of Birth	Social Security Number
Shara DeJesus	**1/15/67**	**133-66-9924**
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Mobin Sadiq MD, 75 North Country Road, Port Jefferson, NY 11777

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 records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Robert Derman MD, 33 Landing Lane, Port Jefferson, NY 11777

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 records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

OCA Official Form No: 960

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).**

7. Name and address of health provider or entity to release this information:
Queens Long Island Med Group, 640 Hawkins Ave., Ronkonkoma, NY 11779

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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 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

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Michael Alan Lee MD, 640 Hawkins Ave., Ronkonkoma, NY 11779

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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

Marci Vella

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Bhanumathy Vinayagasundaram MD, 640 Hawkins Ave., Ronkonkoma, NY 11779

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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 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

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 13, 20~~14~~ 15

3-12-12

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Dana Brenner MD, 200 Belle Terre Rd., Port Jefferson, NY 11777

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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.**

Witness Signature

Notary Public, State of New York
No. 01VE6066139
Qualified in Nassau County
Commission Expires November 13, 20__

1-15-14

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Yanira Raza MD, 6080 Jericho Tnpk., Suite 205, Commack, NY 11725

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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 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

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Elizabeth Jeremias MD, 300 Bay Shore Rd., N. Babylon, NY 11703

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — 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)

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 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

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 10, 20__

OCA Official Form No.: 960

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).**

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 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 records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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.**

MARIE VELLA
Notary Public, State of New York
No. 01VE6086189
Qualified in Nassau County
Commission Expires November 18, 20__

Marie Vella

1-10-11

OCA Official Form No.: 960

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).**

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, 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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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 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

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 13, 20~~12~~ 2015

OCA Official Form No.: 960

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).**

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 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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Donald Phillibert MD, 1901 1st Avenue, NY, NY 10029

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Stony Brook Univ. Hospital, 100 Nicolls Road, Stony Brook, NY 11794

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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 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

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 19, 20[illegible]

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
HIP Pharmacy, 640 Hawkins Ave., Ronkonkoma 11779

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- ____ **Alcohol/Drug Treatment**
- ____ **Mental Health Information**
- ____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
My Commission Expires 1/18/14

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Medical Group Pharmacy, 650 Hawkins Ave., Ronkonkoma 11779

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- ___ **Alcohol/Drug Treatment**
- ___ **Mental Health Information**
- ___ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Prescription Den Pharmacy, 239 Boyle Rd., Selden, NY 11784

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 records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- ____ **Alcohol/Drug Treatment**
- ____ **Mental Health Information**
- ____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

1-18-14

OCA Official Form No.: 960

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).**

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) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **Employment records**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — 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)

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 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

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

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
Medicaid, 222 Church Street, NY, NY 10008

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 records sent to you by other health care providers.
- ☐ Other: **BZ41670G**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires November 18, 20__

Marci Vella

1-18-14

OCA Official Form No.: 960

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).**

7. Name and address of health provider or entity to release this information:
HIP, 55 Water Street, NY, NY 10041-8190

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 records sent to you by other health care providers.

☑ Other: **Insurance records ID # 15601311**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) 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)

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: **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 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

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

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 24th day of March, 2011.

Shara DeJesus

Shara DeJesus

State of New York)
) ss.:
County of Nassau)

On the 24th day of March, 2011, 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

MARCI VELLA
Notary Public, State of New York
No. 01VE6063189
Qualified in Nassau County
Commission Expires November 13, 20__

1-18-11

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

Mary Bravmann, 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

Mary Bravmann

Sworn to before me this
12th day of March, 2012

Notary Public

MARCI VELLA
Notary Public, State of New York
No. 01VE6066189
Qualified in Nassau County
Commission Expires ~~November 15, 20__~~
1/18/14

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