INDEX NO. 613549/2017 NASSAU COUNTY CLERK 08/01/2018 03:56 PM NYSCEF DOC. NO. RECEIVED NYSCEF: 08/01/2018 SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF NASSAU LISA M. D'AVANZO, Plaintiff, Index No. 613549/2017 -against-**RESPONSE TO COMBINED DEMANDS** PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD OF NASSAU COUNTY, INC., BRONWYN FITZ, M.D., NASSAU HEALTH CARE CORPORATION, d/b/a NASSAU UNIVERSITY MEDICAL CENTER, IRWIN GOLDSTEIN, M.D., and LONG ISLAND OB GYN ASSOCIATES, Defendants. PLEASE TAKE NOTICE that the following is plaintiff's response to the combined demands of defendants: AS AND FOR A RESPONSE TO DEMAND FOR ATTORNEYS APPEARING The names and addresses of the attorneys appearing in this action are listed below. AS AND FOR A RESPONSE TO DEMAND FOR AUTHORIZATIONS Attached hereto are duly executed authorizations to obtain the medical records from the following providers: Nassau University Medical Center a. 2201 Hempstead Turnpike East Meadow, NY 11554 Planned Parenthood of Nassau County (Bronwyn Fitz, M.D.) b. 540 Fulton Avenue Hempstead, NY 11550 South Nassau Communities Hospital C. 1 Healthy Way Oceanside, NY 11572

d.

Irwin Goldstein, M.D.

Massapequa, NY 11758

79 Grand Avenue

Long Island OB GYN Associates

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#### AS AND FOR A RESPONSE TO DEMAND FOR EXPERT INFORMATION

Expert information will be supplied under separate cover.

#### AS AND FOR A RESPONSE TO DEMAND FOR WITNESS INFORMATION

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

#### AS AND FOR A RESPONSE TO DEMAND FOR CERTIFICATE OF MERIT

Please find enclosed a copy of the certificate of merit.

#### AS AND FOR A RESPONSE TO DEMAND FOR ADVERSE PARTY STATEMENTS

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

#### AS AND FOR A RESPONSE TO DEMAND FOR PHOTOGRAPHS AND VIDEOS

Plaintiff is not in possession of any photographs or videos.

## AS AND FOR A RESPONSE TO DEMAND FOR **COLLATERAL SOURCE INFORMATION**

Collateral source information will be supplied under separate cover.

Plaintiff is not a Medicare recipient.

Dated: July 30, 2018 Islandia, New York

Yours, etc.

RAPPAPORT, GLASS, LEVINE & ZULLO, LLP

BY:

THOMAS P. VALET

Attorneys for Plaintiff 1355 Motor Parkway Islandia, NY 11749 (631) 293-2300

Heidell, Pittoni, Murphy & Bach, LLP and Long Island OB GYN Associates TO: Attorney For: Irwin Goldstein, M.D.

1050 Franklin Avenue

Garden City, NY 11530-1760

Phone: (516) 408-1600

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Kerley, Walsh, Matera & Cinquemani, P.C.

Attorney For: Nassau Health Care Corporation d/b/a Nassau University Medical

Center

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2174 Jackson Avenue Seaford, NY 11783-2608 Phone: (516) 409-6200

McAloon & Friedman, P.C.

Attorney For: Planned Parenthood of Nassau County, Inc.

123 William Street, 25th Floor New York, NY 10038-3804

Phone: (212) 732-8700

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## **POWER OF ATTORNEY**

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

I, Lisa D'Avanzo
do hereby appoint CHARLES J. RAPPAPORT, MICHAEL G. GLASS, MICHAEL S. LEVINE, MATTHEW J. ZULLO, CHRISTOPHER M. GLASS, MARY ANN RISAVICH-BIRGELES, THOMAS P. VALET of RAPPAPORT, GLASS, LEVINE & ZULLO, LLP, with offices at 1355 Motor Parkway, Islandia, NY 11749, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally to execute HIPAA medical record authorization forms pursuant to New York Public Health Law §18(1)(g) as amended 10/26/04. This power of attorney may be revoked by me at any time. This Power of Attorney shall not be affected by subsequent disability or incompetence.
To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that arise against such third party by reason of such third party having relied on the provisions of this instrument.
In Witness Whereof I have hereunto signed my name this <u>21st</u> day of <u>March</u> , 20 17.
(signature)
Acknowledgment
STATE OF NEW YORK ) )ss.: COUNTY OF )
On this 21st day of March, 20 17 , before me personally appeared Lisa D'Avanzo, known to be, or provided to me on the basis of satisfactory evidence, to be the individual whose name is subscribed to in the within instrument and acknowledged to me that executed the same in his/her capacity, and that by his/her individual signature, executed this instrument and that such individual made such appearance before the undersigned at

Qualified in Nassau County Commission Expires May 11, 2019

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

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

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

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

THAN THE ATTORNET OR GOVERNMENTAL AGENCT STEELINED IN TIEM 5(0).			
7. Name and address of health provider or entity to release this int Nassau University Medical Center, 2201 Hempst			
8. Name and address of person(s) or category of person to whom the McAloon & Friedman, P.C., 123 William Street,			
9(a). Specific information to be released:    Medical information from (insert date x Entire medical record, including patient histories, office records, insurance records, and records sent to you by other health of the seconds.	to (insert date) notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing care providers.		
Other:	Include: (Indicate by Initialing)  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information		
Authorization to Discuss Health Information (b) By initialing here I authorize initial to discuss my health information with my attorney, or a government	Name of individual health care provider		
10. Reason for release of information:  ☐ At request of individual  x Other: Lawsuit related	11. Date or event on which this authorization will expire:  At conclusion of lawsuit		
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact		
All items on this form have been completed and my questions about	t this form have been answered. In addition, I have been provided a copy of this form.		

Signature of Patient or Representative authorized by law.

Date: July 30, 2018

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

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

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

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form;

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

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

THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECI	FIED IN ITEM 9(6),
7. Name and address of health provider or entity to release this inform Planned Parenthood of Nassau County (Bronwyn F	nation: itz, M.D.), 540 Fulton Avenue, Hempstead, NY 11550
8. Name and address of person(s) or category of person to whom this McAloon & Friedman, P.C., 123 William Street, 25	
9(a). Specific information to be released:  □ Medical information from (insert date  x Entire medical record, including patient histories, office note records, insurance records, and records sent to you by other health care  □ Other:  Authorization to Discuss Health Information (b)  □ By initialing here  initial to discuss my health information with my attorney, or a governmental at	Include: (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information  Name of individual health care provider
10. Reason for release of information:  ☐ At request of individual  x Other: Lawsuit related	11. Date or event on which this authorization will expire:  At conclusion of lawsuit
12. If not the patient, name of person signing form:  13. Authority to sign on behalf of patient:  Attorney in fact	

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

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

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

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

- In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

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

THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN TIEM 9(0).			
7. Name and address of health provider or entity to release this inform South Nassau Communities Hospital, 1 Healthy W.			
8. Name and address of person(s) or category of person to whom this McAloon & Friedman, P.C., 123 William Street, 23			
9(a). Specific information to be released:  □ Medical information from (insert date  x Entire medical record, including patient histories, office not records, insurance records, and records sent to you by other health care  □ Other:  Authorization to Discuss Health Information  (b) □ By initialing here I authorize  initial	to (insert date) les (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing e providers.  Include: (Indicate by Initialing)  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information  Name of individual health care provider		
to discuss my health information with my attorney, or a governmental agency, listed here:			
10. Reason for release of information:  ☐ At request of individual  x Other: Lawsuit related	11. Date or event on which this authorization will expire:  At conclusion of lawsuit		
12. If not the patient, name of person signing form:  13. Authority to sign on behalf of patient:  Attorney in fact			

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

City to S. D. divide and D. Control of the Law Inc.

Date: July 30, 2018

Signature of Patient or Representative authorized by law.

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

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

Patient Name LISA D'AVAIIZO	Date of Birth	1988	Social Security Number	
Patient Address 933 Grant Place, Bellmore, NY 11710				
<ol> <li>This authorization may include disclosure of notes, and CONFIDENTIAL HIV* RELATED described below includes any of these types of infindicated in Item 8.</li> <li>If I am authorizing the release of HIV-relate information without my authorization unless permuse my HIV-related information without authoriz New York State Division of Human Rights at (21) protecting my rights.</li> <li>I have the right to revoke this authorization at the extent that action has already been taken base 4. I understand that signing this authorization is my authorization of this disclosure.</li> <li>Information disclosed under this authorization by federal or state law.</li> </ol>	Privacy Rule of the Health Insur- information relating to ALCOI INFORMATION only if 1 place formation, and I initial the line on d, alcohol or drug treatment, or nitted to do so under federal or st ation. If I experience discrimin 2) 480-2493 or the New York Cit any time by writing to the health d on this information. voluntary. My treatment, payn might be redisclosed by the reci	rance Portabilities and DRI and DRI and DRI and DRI and initials of the box in Itel and attention because by Commission care provider acnt, enrollme pient (except and MY HEALT	tent be released as set forth on this form: ty and Accountability Act of 1996 (HIPAA), I understand that: IG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy in the appropriate line in Item 9(a). In the event the health information in 9(a), I specifically authorize release of such information to the person(s) treatment information, the recipient is prohibited from redisclosing such lerstand that I have the right to request a list of people who may receive or of the release or disclosure of HIV-related information, I may contact the in of Human Rights at (212) 306-7450. These agencies are responsible for listed below. I understand that I may revoke this authorization except to int in a health plan, or eligibility for benefits will not be conditioned upon its noted above in Item 2), and this redisclosure may no longer be protected H INFORMATION OR MEDICAL CARE WITH ANYONE OTHER	
7. Name and address of health provider or entity Irwin Goldstein, M.D., Long Island 8. Name and address of person(s) or category of McAloon & Friedman, P.C., 123 W	OB GYN Associates, 7	n will be sent:		
9(a). Specific information to be released;  □ Medical information from (insert date	nt histories, office notes (except	to (insert of psychotherapy		
Authorization to Discuss Health Information (b) By initialing here I authorize initial to discuss my health information with my attorned	Name of		Ith care provider	
10. Reason for release of information;  D At request of individual x Other: Lawsuit related		e or event on aclusion of	which this authorization will expire:	
12. If not the patient, name of person signing for Thomas P. Valet	Attorn	ey in fact	on behalf of patient:	
All items on this form have been completed and r	Da	e been answer te: July 30,	ed. In addition, I have been provided a copy of this form.	

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

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Patient Address 933 Grant Place, Bellmore, NY 11710			

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- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
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TABLE THE ATTOCKED TO CONTRACT THE PARTIES IN TILE A 70.			
7. Name and address of health provider or entity to release this information;			
Nassau University Medical Center, 2201 Hempstead Turnpike, East Meadow, NY 11554			
14dSad Oniversity Medical Center, 2201 Hempstead Turnprice, Last Meddow, 141 11554			
8. Name and address of person(s) or category of person to whom this information will be sent:			
Kerley, Walsh, Matera & Cinquemani, P.C., 2174 Jackson Avenue, Seaford, NY 11783			
rection, water & Onique main, 1.C., 2174	Saokson Trondo, Beatord, 141 11705		
9(a). Specific information to be released:			
ra Medical information from (insert date	to (insert date)		
x Entire medical record including patient histories office n	otes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing		
records, insurance records, and records sent to you by other health ca	tre providers		
Other:	Local des / Le diseate les Teldislines		
	Alcohol/Drug Treatment		
	Mental Health Information		
	HIV-Related Information		
Authorization to Discuss Health Information	**************************************		
(b) By initialing here I authorize			
initial Name of individual health care provider			
to discuss my health information with my attorney, or a governmental agency, listed here:			
10. Reason for release of information:	11. Date or event on which this authorization will expire:		
☐ At request of individual	· ·		
x Other: Lawsuit related	At conclusion of lawsuit		
	THE CONTOURS ON THE PRODUCT		
12. If not the patient, name of person signing form:  13. Authority to sign on behalf of patient;			
Thomas P. Valet	Attorney in fact		

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

Date: July 30, 2018

Signature of Patient or Representative authorized by law.

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THAN THE ATTORNET OR GOVERNMENTAL AGENC I SPEC	if ied in them a(b).	
7. Name and address of health provider or entity to release this infor Planned Parenthood of Nassau County (Bronwyn 1	mation: Fitz, M.D.), 540 Fulton Avenue, Hempstead, NY 11550	
8. Name and address of person(s) or category of person to whom the Kerley, Walsh, Matera & Cinquemani, P.C., 2174		
9(a). Specific information to be released:  One Medical information from (insert date  x Entire medical record, including patient histories, office not records, insurance records, and records sent to you by other health car	to (insert date)to (insert date)to (insert date)to test results, radiology studies, films, referrals, consults, billing re providers.	
🗆 Other:	Include: (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information	
Authorization to Discuss Health Information  (b) Discuss Health Information  (b) Discuss Health Information  I authorize  Initial Name of individual health care provider  to discuss my health information with my attorney, or a governmental agency, listed here:		
10. Reason for release of information: □ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire:  At conclusion of lawsuit	
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact	
All items on this form have been completed and my questions about t	his form have been answered. In addition, I have been provided a copy of this form.	

Signature of Patient or Representative authorized by law.

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Patient Name Lisa D'Avanzo	Date of Birth 1988	Social Security Number
Patient Address 933 Grant Place, Bellm	ore, NY 11710	

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In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

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

THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECI	IFIED IN THEM 9(b).	
7. Name and address of health provider or entity to release this informations South Nassau Communities Hospital, 1 Healthy W		
8. Name and address of person(s) or category of person to whom this Kerley, Walsh, Matera & Cinquemani, P.C., 2174.		
records, insurance records, and records sent to you by other health care		
Other:  Authorization to Discuss Health Information  (b)   By initialing here I authorize initial	Include: (Indicate by Initialing)  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information	
initial Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here:		
10. Reason for release of information: ☐ At request of individual x Other: Lawsuit related	11. Date or event on which this authorization will expire:  At conclusion of lawsuit	
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact	
All items on this form have been completed and my questions about the	nis form have been answered. In addition, I have been provided a copy of this form.	

Signature of Patient or Representative authorized by law.

Date: July 30, 2018

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

RECEIVED NYSCEF: 08/01/2018

INDEX NO. 613549/2017

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

Patient Name Lisa D'Avanzo	Date of Birth	1988	Social Security Number
Patient Address 933 Grant Place, Bellm	ore, NY 1171	0	
<ol> <li>This authorization may include disclosure of notes, and CONFIDENTIAL HIV* RELATED described below includes any of these types of intindicated in Item 8.</li> <li>If I am authorizing the release of HIV-relate information without my authorization unless per use my HIV-related information without authorit. New York State Division of Human Rights at (21 protecting my rights.</li> </ol>	Privacy Rule of the information relatin INFORMATION or ormation, and I initial, alcohol or drug traitted to do so under ation. If I experien 2) 480-2493 or the N	Health Insurance Portabiling to ALCOHOL and DRU and DRU and I place my initials of all the line on the box in Iter eatment, or mental health federal or state law. I under discrimination because lew York City Commission	ty and Accountability Act of 1996 (HIPAA), I understand that: JG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy in the appropriate line in Item 9(a). In the event the health information in 9(a), I specifically authorize release of such information to the person(s treatment information, the recipient is prohibited from redisclosing such derstand that I have the right to request a list of people who may receive o of the release or disclosure of HIV-related information, I may contact the nof Human Rights at (212) 306-7450. These agencies are responsible for
<ol> <li>I have the right to revoke this authorization at the extent that action has already been taken based.</li> <li>I understand that signing this authorization is my authorization of this disclosure.</li> <li>Information disclosed under this authorization by federal or state law.</li> </ol>	d on this informatio voluntary. My trea might be redisclose THORIZE YOU TO	n. Afment, payment, enrollment of by the recipient (except and DOISCUSS MY HEALT	listed below. I understand that I may revoke this authorization except to nt in a health plan, or eligibility for benefits will not be conditioned upon as noted above in Item 2), and this redisclosure may no longer be protected. THE INFORMATION OR MEDICAL CARE WITH ANYONE OTHER
7. Name and address of health provider or entit Irwin Goldstein, M.D., Long Island			venue, Massapequa, NY 11758
8. Name and address of person(s) or category o Kerley, Walsh, Matera & Cinquema	person to whom thi	is information will be sent	
9(a). Specific information to be released:    Medical information from (insert date x Entire medical record, including patie records, insurance records, and records sent to your Other:    Authorization to Discuss Health Information (b)   By initialing here I authoritial to discuss my health information with my attorned.	nt histories, office no u by other health ca e	re providers. Included: Name of individual hea	rnotes), test results, radiology studies, films, referrals, consults, billing de: (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information
10. Reason for release of information:  D At request of individual		11. Date or event on	which this authorization will expire:

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

Date: July 30, 2018

Signature of Patient or Representative authorized by law.

12. If not the patient, name of person signing form:

x Other: Lawsuit related

Thomas P. Valet

Attorney in fact

At conclusion of lawsuit

13. Authority to sign on behalf of patient:

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

INDEX NO. 613549/2017

RECEIVED NYSCEF: 08/01/2018

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

Patient Name Lisa D'Avanzo	Date of Birth 1988	Social Security Number	
Patient Address 933 Grant Place, Bellm	ore, NY 11710		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

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

	(-)	
7. Name and address of health provider or entity to release this Nassau University Medical Center, 2201 Hem		
8. Name and address of person(s) or category of person to who Heidell, Pittoni, Murphy & Bach, LLP, 1050 F		
9(a). Specific information to be released:  Dedical information from (insert date x Entire medical record, including patient histories, off records, insurance records, and records sent to you by other heal	to (insert date) ice notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing th care providers.	
Other:  -Authorization to Discuss Health Information	Include: (Indicate by Initialing)  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information	
(b)   By initialing here I authorize initial to discuss my health information with my attorney, or a government of the state of the sta	Name of individual health care provider nental agency, listed here:	
10. Reason for release of information:  ☐ At request of individual  x Other: Lawsuit related	11. Date or event on which this authorization will expire:  At conclusion of lawsuit	
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact	
	. 4 6 4 4 4 7 4 9 5 7 4 7 6 7 6 7 6 7 7 7 7 7 7 7 7 7 7 7 7	

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

Signature of Patient or Representative authorized by law.

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

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RECEIVED NYSCEF: 08/01/2018

#### AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA This form has been approved by the New York State Department of Health 1

Patient Name Lisa D'Avanzo	Date of Birth 1988	Social Security Number
Patient Address 933 Grant Place, Bellm	ore, NY 11710	

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

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

THAN THE ATTUKNET OR GOVERNMENTAL AGENCY SPECI	PIED IN ITEM 9(b).	
7. Name and address of health provider or entity to release this infom Planned Parenthood of Nassau County (Bronwyn F	nation: itz, M.D.), 540 Fulton Avenue, Hempstead, NY 11550	
8. Name and address of person(s) or category of person to whom this Heidell, Pittoni, Murphy & Bach, LLP, 1050 Frank		
9(a). Specific information to be released:  ☐ Medical information from (insert date  x Entire medical record, including patient histories, office not records, insurance records, and records sent to you by other health care  ☐ Other:	T1-4 (T1)	
Authorization to Discuss Health Information  (b) By initialing here I authorize initial Name of individual health care provider  to discuss my health information with my attorney, or a governmental agency, listed here:		
10. Reason for release of information;  ☐ At request of individual  x Other: Lawsuit related	11. Date or event on which this authorization will expire:  At conclusion of lawsuit	
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact	

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

Signature of Patient or Representative authorized by law.

Date: July 30, 2018

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

RECEIVED NYSCEF: 08/01/2018

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

Patient Name Lisa D'Avanzo	Date of Birth 1988	Social Security Number
Patient Address 933 Grant Place, Bellm	ore, NY 11710	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

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

THAN THE ATTURNET OR GOVERNMENTAL AGENCY SPECI	THEID IN THEM 9(b).	
7. Name and address of health provider or entity to release this inform South Nassau Communities Hospital, 1 Healthy Wa		
"8." Name and address of person(s) or category of person to whom this Heidell, Pittoni, Murphy & Bach, LLP, 1050 Frankl		
9(a). Specific information to be released:  Description:	to (insert date) es (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing providers.	
G Other:	Include: (Indicate by Initialing)  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information	
Authorization to Discuss Health Information (b) By initialing here I authorize		
initial to discuss my health information with my attorney, or a governmental a	Name of individual health care provider gency, listed here:	
10. Reason for release of information:  ☐ At request of individual  x Other; Lawsuit related	11. Date or event on which this authorization will-expire:  At conclusion of lawsuit	
12. If not the patient, name of person signing form: Thomas P. Valet	13. Authority to sign on behalf of patient: Attorney in fact	

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

Date

Date: July 30, 2018

Signature of Patient or Representative authorized by law.

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

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## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]		
Patient Name Lisa D'Avanzo	Date of Birth	Social Security Number
Patient Address 933 Grant Place, Bellm	ore, NY 11710	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

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- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV\* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
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- 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).

THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).		
7. Name and address of health provider or entity to release this information; Irwin Goldstein, M.D., Long Island OB GYN Associates, 79 Grand Avenue, Massapequa, NY 11758		
8. Name and address of person(s) or category of person to whom this information will be sent: — Heidell, Pittoni, Murphy & Bach, LLP, 1050 Franklin Avenue, Garden City, NY 11530		
9(a). Specific information to be released:    Medical information from (insert date		
to discuss my health information with my attorney, or a governmental agency, listed here:		
10. Reason for release of information:  11. Date or event on which this authorization will expire:  12. At request of individual  2. Other: Lawsuit related  At conclusion of lawsuit		
12. If not the patient, name of person signing form:  Thomas P. Valet  13. Authority to sign on behalf of patient:  Attorney in fact		

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

Signature of Patient or Representative authorized by law.

Date; July 30, 2018

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

COUNTY CLERK 08/01/2018 03:56 PM

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## AFFIDAVIT OF SERVICE

#### STATE OF NEW YORK, COUNTY OF SUFFOLK ss.:

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

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

Heidell, Pittoni, Murphy & Bach, LLP

Attorney For: Irwin Goldstein, M.D. and Long Island OB GYN Associates

1050 Franklin Avenue

Garden City, NY 11530-1760

Phone: (516) 408-1600

Kerley, Walsh, Matera & Cinquemani, P.C.

Attorney For: Nassau Health Care Corporation d/b/a Nassau University Medical Center

2174 Jackson Avenue Seaford, NY 11783-2608 Phone: (516) 409-6200

McAloon & Friedman, P.C.

Attorney For: Planned Parenthood of Nassau County, Inc.

123 William Street, 25th Floor New York, NY 10038-3804 Phone: (212) 732-8700

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

Kylaoni

Sworn to before me on Monday, July 30, 2018

Notary Public

EMMA M. NARAIN Notary Public, State of New York No. 01NA6185272

Qualified in Nassau County Commission Expires April 14,