



Recupera Records  
185 Great Neck Rd  
Great Neck, NY 11021  
Tel: (212) 213-6659

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**FACSIMILE TRANSMITAL SHEET**

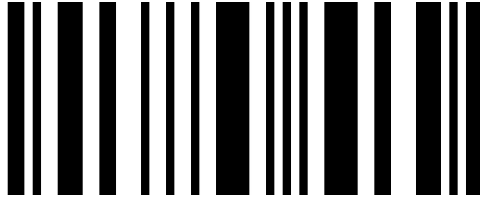
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TO: Records Custodian	FROM:
COMPANY: AFC Urgent Care	DATE: November 21st, 2025
PHONE NUMBER: (631) 983-4084	RECORDS OF: Juan Ochoa
FAX NUMBER: (631) 983-4085	SENDER REFERENCE NUMBER: 1185

RE:

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Thank You,  
Recupera Records  
Great Neck, NY 11021  
Phone: (212) 213-6659  
Fax: (212) 213-1715



AFC Urgent Care  
125 Sunrise Highway  
West Islip, NY 11795

Recupera #: 1185

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION  
IN ACCORDANCE WITH 45 CFR §164.508-HIPAA  
Approved for use by the San Antonio Bar Association and Bexar County Medical Society**

I hereby authorize \_\_\_\_\_ to disclose my Protected Health Information (PHI) as contained in the records maintained by \_\_\_\_\_, including but not limited to highly confidential information concerning communicable diseases, HIV, AIDS, *psychiatric*, chemical or alcohol dependency, laboratory test results, or any other medical treatment. **This authorization does/does not [please circle selection] include psychotherapy notes.**

**PATIENT IDENTIFICATION INFORMATION**

Account or medical record number \_\_\_\_\_

Patient's name Ochoa Juan  
Last First Middle

Social Security No. \_\_\_\_\_ Date of Birth 08/13/1966

Name and address of recipient: \_\_\_\_\_

The release of the materials listed is being authorized for use as evidence in a legal proceeding involving this patient. You understand that such information cannot be released without the patient's specific consent. **You are authorized to comply with an original or copy of this document.**

**DESCRIPTION OF INFORMATION TO BE RELEASED**

The matters to be released pursuant to this authorization are as follows: any and all medical or reports, x-rays (if requested), diagnostic studies, laboratory slides (if requested), clinical abstracts, histories, charts, admission sheet, system history or system review, summary sheet, medical service sheet, nurse's notes, discharge notes, chronological survey, consultant reports, any patient records not located in the medical record library (such as emergency room records), any *counseling* records, and any correspondence, including any hand-written or typed notes of or from any nurse, doctor, physician, surgeon, or any other person, and any other information, documents and opinions relevant to past, present and future, physical, mental and/or emotional conditions, treatment, or hospitalization.

This authorization includes the release of documents in your possession whether or not created in your office or by another healthcare provider.

I understand that this authorization will expire on \_\_\_\_\_ or 180 days from the date of this signed authorization, whichever comes first.  
Date

I understand that the information released in response to this authorization is subject to disclosure to other parties, and that any other person, firm or entity that releases materials pursuant to this authorization is released from any liability that might otherwise result from the release of this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the physician or appropriate healthcare provider. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form.

You are authorized to comply with an original or copy of this authorization dated on this the 8<sup>th</sup> day of February, 2024.

[Signature]  
Patient or patient's - representative (including their relationship to patient)  
or patient's guardian (if the patient is a minor or incapacitated adult)

2/8/24  
Date

HOSPITAL

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION  
IN ACCORDANCE WITH 45 CFR §164.508-HIPAA**

Approved for use by the San Antonio Bar Association and Bexar County Medical Society

I hereby authorize \_\_\_\_\_ to disclose my Protected Health Information (PHI) as contained in the records maintained by \_\_\_\_\_, including but not limited to highly confidential information concerning communicable diseases, HIV, AIDS, psychiatric, chemical or alcohol dependency, laboratory test results, or any other medical treatment. **This authorization does/does not [circle selection] include psychotherapy notes.**

PATIENT IDENTIFICATION INFORMATION

Account or medical record number \_\_\_\_\_

Patient's name Ochoa Juan  
Last First Middle

Social Security No. \_\_\_\_\_ Date of Birth 08/13/1966

Name and address of recipient: \_\_\_\_\_

The release of the matters listed is being authorized for use as evidence in a legal proceeding involving this patient. You understand that such information cannot be released without the specific consent. You are authorized to comply with an original or copy of this document.

DESCRIPTION OF INFORMATION TO BE RELEASED

Please initial the materials to be released pursuant to this authorization:

- |   |  |   |
|---|--|---|
| <input checked="" type="checkbox"/> any and all medical records/reports   | <input type="checkbox"/> system history or system review   | <input type="checkbox"/> any counseling records   |
| <input type="checkbox"/> x-rays (if requested)  | <input type="checkbox"/> summary sheet   | <input type="checkbox"/> admission sheet  |
| <input type="checkbox"/> diagnostic studies   | <input type="checkbox"/> medical service sheet   | <input type="checkbox"/> charts   |
| <input type="checkbox"/> laboratory slides (if requested)   | <input type="checkbox"/> nurses notes  | <input type="checkbox"/> consultant reports   |
| <input type="checkbox"/> clinical abstracts   | <input type="checkbox"/> discharge notes   | <input type="checkbox"/> any patient records not located in the<br>medical record library |
| <input type="checkbox"/> histories  | <input type="checkbox"/> chronological survey  | (such as emergency room records)  |
| <input type="checkbox"/> any correspondence, including any<br>hand-written or typed notes of or<br>from any nurse, doctor, physician,<br>surgeon, or any other person | <input type="checkbox"/> any other information, documents<br>and opinions relevant to past, present<br>and future, physical, mental and/or<br>emotional conditions, treatment, or<br>hospitalization |   |

This authorization includes the release of documents in your possession whether or not created in your office or by another healthcare provider.

I understand that this authorization will expire on \_\_\_\_\_ or 180 days from the date of this signed authorization.  
Date

I understand that the information released in response to this authorization is subject to disclosure to other parties, and that any other person, firm or entity that releases material pursuant to this authorization is released from any liability that might otherwise result from the release of this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the physician or appropriate healthcare provider. I understand that the revocation will not apply to information that has already been released in response to this authorization.


I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form.

You are authorized to comply with an original or copy of this authorization dated on this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

[Signature] \_\_\_\_\_ Date \_\_\_\_\_  
Patient, the patient's personal representative  
or patient's guardian (if the patient is a minor or incapacitated adult)

# RECUPERA

Secure. Accurate. On Time.



November 21st, 2025

To Whom It May Concern:

Please allow this correspondence to confirm that Perri Law LLP utilizes the services of **Recupera Record Services** to process authorizations on our behalf to obtain records indicated on the attached authorization.

Kindly honor the authorization releasing information to **Recupera Record Services** as if it were our office requesting the records.

**PLEASE SEND ALL REQUESTS FOR PAYMENTS AND THE RECORDS TO:**

**Recupera Record Services  
Medical Records Retrieval  
185 Great Neck Rd  
Great Neck, NY 11021**

If you have any questions regarding this matter, please feel free to contact our office. Thank you for your courtesy and cooperation.

Yours sincerely,

*Joseph Broccoli*

**Joseph Broccoli**  
Paralegal  
for Kennedys

Kennedys is a trading name of Kennedys CMK LLP. Kennedys Law LLP, a UK Limited Liability Partnership, is a partner of Kennedys CMK LLP

*Kennedys offices, associations and cooperations:* Argentina, Australia, Belgium, Bermuda, Brazil, Chile, China, Colombia, Denmark, Dominican Republic, England and Wales, France, Guatemala, Hong Kong, India, Ireland, Israel, Italy, Mexico, New Zealand, Northern Ireland, Norway, Pakistan, Panama, Peru, Poland, Portugal, Puerto Rico, Russian Federation, Scotland, Singapore, Spain, Sweden, Thailand, United Arab Emirates, United States of America.

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**CERTIFICATION OF SATISFACTORY ASSURANCE**

Pursuant to 45 C.F.R. §16a.512(e)(1)

PATIENT: Juan Ochoa

DOB:

As required by the Standards for Privacy of Individually Identifiable Health Information ("Privacy Act") promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this certification provides satisfactory assurances that appropriate steps have been taken to notify and/or otherwise protect the privacy of the individual who is the subject of the protected health information that is being requested.

**Notice**

In compliance with 45 C.F.R. §16a.512(e)(1), I hereby certify, that I have made a good faith attempt to provide written notice to Juan Ochoa the individual, or if the individual's location is unknown, to make a notice to the individual's last known address or legal representation.

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, ZipCode: \_\_\_\_\_

A copy of such notice is attached to this Certification

I further certify that the notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise and objection to the court or administrative tribunal. I further certify that the time for the individual to raise objections to the court or administrative tribunal has elapsed and either: (1) no objections were filed; or (2) all objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

(X) Qualified Protective Order

In compliance with 45 C.F.R. §16a.512(e)(1), I hereby certify that the parties to the dispute giving rise to this request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute. A copy of the qualified protective order, or my request for such order, is attached hereto.

**Joel Davis**  
Name

November 21st, 2025  
Date

**/s/ Joel Davis**  
Signature

Perri Law LLP  
Company