Recupera Records

185 Great Neck Rd

Great Neck, NY 11021

Tel: (212) 213-6659

FACSIMILE TRANSMITAL SHEET

TO: Records Custodian	FROM:
COMPANY: 1 Florida Health, Inc.	DATE: January 27th, 2026
PHONE NUMBER:	RECORDS OF: John Smith
FAX NUMBER:	SENDER REFRENCE NUMBER: 3300

RE:

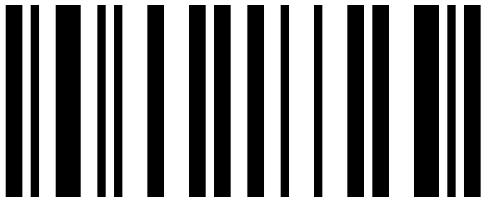
Thank You,

Recupera Records

Great Neck, NY 11021

Phone: (212) 213-6659

Fax: (212) 213-1715



1 Florida Health, Inc.
c/o Registered Agent, Zeri Zapata
7000 W Oakland Park Blvd, Suite 204
Fort Lauderdale, FL Sunrise

Recupera #: 3300

Recupera Record Retrieval Services
185 Great Neck Road Suite 403
Great Neck, NY 11021
Phone: (212) 580-1191 / Fax: (212) 213-1715
Email: Records@recuperars.com

VIA:

ATTN: Custodian of Records:

1 Florida Health, Inc.
c/o Registered Agent, Zeri Zapata
7000 W Oakland Park Blvd, Suite 204
Fort Lauderdale, FL Sunrise

Please Find Enclosed a request for records of:

PATIENT: John Smith
DOB:
SSN:

On behalf of Perri Law LLP, Recupera is a third party records retrieval company that is handling the retrieval of records for this matter involving the above mentioned patient. Please direct any questions or concerns to Recupera. Any prepayment invoices or film breakdowns need to be sent to Recupera. Attached is a signed authorization provided to us from our client, Perri Law LLP, in order to obtain the following requested records per the authorization attached.

If copy costs exceed $500.00 please contact Recupera Record Retreival Services LLC
for approval prior to sending records.

RUSH CASE – PLEASE EXPIDITE
PLEASE SEND RECORDS WITHIN TEN DAYS

We need these records and legal documents returned BEFORE: As soon as possible

[X] Subpoena

[ ] Written Questions

[ ] Affidavit

[ ] Cross Questions

[ ] Affidavit of No Record

[ ] Authorization

Contact: Records Retrieval Department

Recupera Oder Number: 3300

CERTIFICATION OF SATISFACTORY ASSURANCE

Pursuant to 45 C.F.R. $16a.512(e)(1)

PATIENT: John Smith 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.

(X) **Notice**

In compliance with 45 C.F.R. $16a.512(e)(l), I hereby certify, that I have made a good faith attempt to provide written notice to John Smith 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:	Attorney in SC Office
Street Address:	1 Main Street
City, State, ZipCode:	Smithtown, NY 11787

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: (l) 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.

_____ 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.

Joe Test123
Name

January 27th, 2026
Date

/s/ Joe Test123
Signature

Perri Law LLP
Company

Recupera # 3300

ORLEANS COUNTY SUPREME COURT
CIVIL DIVISION

O'Connor, Patrick
Plaintiff(s)
v.
Granite Ridge Manufacturing, Inc.
Defendant(s)

Case No.: 2024-CV-088765

SUBPOENA DUCES TECUM WITHOUT DEPOSITION

To: RECORDS CUSTODIAN
1 Florida Health, Inc.
c/o Registered Agent, Zeri Zapata
7000 W Oakland Park Blvd, Suite 204
Fort Lauderdale, FL Sunrise

YOU ARE HEREBY COMMANDED to produce the following records for inspection and copying **within fifteen (15) days of your receipt** of this subpoena, by mailing, faxing, or securely delivering them to in electronic format on CD or via E-Mail to Records@recuperars.com.

RECORDS OF John Smith

ALL BILLING RECORDS, INCLUDING ALL BILLING LEDGERS, AND ALL STATEMENTS REFLECTING PAYMENTS AND ADJUSTMENTS MADE BY OR ON BEHALF OF PATIENT. INCLUDE ANY AND ALL HCFA/CMS-1500 BILLING FORMS AND/OR UB-92/UB-04 FORMS, BILLING R&N, AND BILLING HB 4 FORMS, ALL CPT OR PROCEDURE CODES, HCPCS CODES, ICD-9 CODES, ICD-10 CODES AND ANY AND ALL "E" CODES ASSOCIATED WITH THE PRIMARY DOCTOR, AS WELL AS ANY AND ALL LETTERS OF PROTECTION YOU HAVE RECEIVED AS IT PERTAINS TO THE ABOVE-NAMED INDIVIDUAL.

PLEASE PROVIDE A FULL AND COMPLETE FILM BREAKDOWN (FORM ATTACHED) OF ALL FILMS OF ANY TYPE (MRI, CT, X-RAY, ULTRASOUND, ETC.) PRIOR TO DUPLICATION AND ORDER. ALL RECORDS SHOULD BE ALL INCLUSIVE AND SHOULD IN NO WAY BE LIMITED TO ONE INCIDENT.

SEND ELECTRONIC RECORDS AND INVOICE TO: RECORDS@RECUPERARS.COM OR CD OF RECORDS TO:

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
Patient Address		

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:

8. Name and address of person(s) or category of person to whom this information will be sent:

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: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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: _____

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.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.