Recupera Records

185 Great Neck Rd
Suite 403

Great Neck, NY 11021

Tel: (212) 580-1191

FACSIMILE TRANSMITAL SHEET

TO: Records Custodian	FROM: Recupera Record Retrieval Services
COMPANY: A Woman's Place	DATE: February 2nd, 2026
PHONE NUMBER: (732) 747-9310	RECORDS OF: Joe Smith
FAX NUMBER: 732) 747-9320	SENDER REFRENCE NUMBER: 3342

RE:

Requesting Medical, Billing and Films Records for dates of service indicated in attached.

*****Rush Case Please Expedite*****

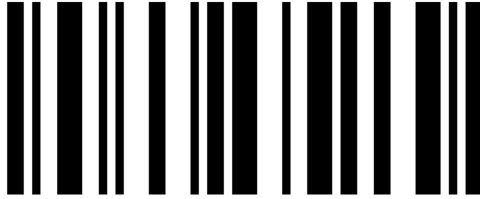
Thank You,

Recupera Records

Great Neck, NY 11021

Phone: (212) 580-1191

Fax: (212) 213-1715



A Woman's Place
34 Sycamore Avenue, Suite 2A
Little Silver, NJ 07739

Recupera #: 3342

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

ATTN: Custodian of Records:

A Woman's Place
34 Sycamore Avenue, Suite 2A
Little Silver, NJ 07739

Please Find Enclosed a request for records of:

PATIENT: Joe Smith
DOB: 01/23/1980
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 IMMEDIATELY

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

[X] Subpoena	[ ] Cross Questions
[ ] Written Questions	[ ] Affidavit of No Record
[ ] Affidavit	[ ] Authorization

Contact: Records Retrieval Department

Recupera Oder Number: 3342

CERTIFICATION OF SATISFACTORY ASSURANCE

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

PATIENT: Joe Smith DOB: 01/23/1980

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. § 164.512(e)(1), I hereby certify, that I have made a good faith attempt to provide written notice to Joe 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 Edit Update	February 2nd, 2026
Name	Date
/s/ Joe Edit Update	Perri Law LLP
Signature	Company

Recupera # 3342

LOS ANGELES COUNTY SUPERIOR COURT-CIVIL/SMALL CLAIMS CIVIL DIVISION

Singh, Arjun
Plaintiff(s)
v.
Summit Medical Imaging, P.A.
Defendant(s)

Case No.: 2025-CV-024881

SUBPOENA DUCES TECUM FOR DISCOVERY - RECORDS ONLY (R. 4:14-7(c))

YOU ARE HEREBY COMMANDED to produce the documents and other tangible things described below for inspection and copying.

THIS IS A RECORDS-ONLY SUBPOENA: No oral testimony is requested, and no personal appearance is required if you produce the requested records as directed.

RECORDS DEPOSITION / PRODUCTION DATE (do not produce before this date):
___________________________________ at _________ ☐ a.m. / ☐ p.m.

YOU ARE ALSO COMMANDED to produce, on or before the records deposition / production date stated above, the following described books, papers, documents and other tangible things:

RECORDS OF Joe Smith

ANY AND ALL WRITTEN AND ELECTRONIC DOCUMENTS, CORRESPONDENCE, RECORDS AND ITEMIZED STATEMENTS OF CHARGES, INCLUDING BUT NOT LIMITED TO: ALL OFFICE, EMERGENCY ROOM, IN-PATIENT AND OUT-PATIENT CHARTS AND RECORDS, DOCTORS' AND NURSES' NOTES, PAYMENT HISTORY, COPIES OF FILMS, RADIOLOGICAL REPORTS, MRI FILMS, CT SCANS, COLORED INTRA-OPERATIVE PHOTOGRAPHS, INSURANCE DOCUMENTS, INITIAL PATIENT QUESTIONNAIRE, SIGN IN SHEETS, ELECTRONIC RECORDS, ALL PHARMACY RECORDS, ALL DIAGNOSTIC FILMS AND REPORTS, ALL DESCRIPTIONS OF EXERCISES PRESCRIBED, ALL PHYSICAL THERAPY RECORDS, DOCUMENTATION WHICH INDICATE DATE AND TIME OF PATIENT’S APPOINTMENTS REGARDLESS OF TREATMENT DATE, ANY AND ALL REPORTS OR CORRESPONDENCE INCLUDING BUT NOT LIMITED TO OTHER PHYSICIANS OR OTHER HOSPITALS

IN YOUR FILE, INCLUDING CD ROM, TAPE DRIVE, FLOPPY DRIVE, HARD DRIVE, SCANNED DOCUMENTS, AND ALL OTHER DOCUMENTS STORED ELECTRONICALLY OR DIGITALLY. INCLUDE PHYSICIAN'S CURRICULUM VITAE, AND EVERY WRITTEN PIECE OF PAPER INCLUDED WITHIN THE PATIENTS CHART, INCLUDING A COPY OF ANY NOTATIONS ON THE FILE JACKET.

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.

NOTICE / LIMITATIONS (R. 4:14-7(c))

The subpoenaed evidence shall not be produced or released until the records deposition / production date specified above.

If the deponent is notified that a motion to quash the subpoena has been filed, the deponent shall not produce or release the subpoenaed evidence until ordered to do so by the court or until release is consented to by all parties.

This subpoena must be served on the witness and on all parties no less than ten (10) days prior to the records deposition / production date scheduled above.

PRODUCTION OF RECORDS (NO TESTIMONY REQUIRED)

You may comply by mailing, faxing, or securely delivering the responsive records to records@recuperars.com (preferred) or to the address listed below. Please include Recupera # 3342 on all correspondence and invoices. Do not produce or release the records before the records deposition / production date stated above, and do not produce if you are notified that a motion to quash or other application has been filed, unless ordered by the court or consented to in writing by all parties.

HIPAA NOTICE AND COMPLIANCE

THIS SUBPOENA HAS BEEN ISSUED IN COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), 45 C.F.R. §164.512(e), WHICH PERMITS THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) IN RESPONSE TO A VALID SUBPOENA THAT:

LIMITS THE SCOPE OF RECORDS REQUESTED TO WHAT IS RELEVANT AND MATERIAL TO A PENDING LEGAL MATTER.

INCLUDES GOOD FAITH ATTEMPTS TO PROVIDE WRITTEN NOTICE TO THE ABOVE-NAMED PATIENT THAT HIS/HER PROTECTED HEALTH INFORMATION HAS BEEN SUBPOENAED; AND

IS ISSUED THROUGH LAWFUL PROCESS (E.G., A COURT OR ATTORNEY-AUTHORIZED SUBPOENA), AND THE TIME FOR THE PATIENT OR THEIR REPRESENTATIVE TO FILE OBJECTIONS HAS ELAPSED.

NO OBJECTIONS WERE FILED, OR ALL OBJECTIONS WERE HEARD AND RESOLVED, AND THE DISCLOSURE WAS DETERMINED TO BE REASONABLE AND APPROPRIATE.

Dated this 2nd of February, 2026

/s/ Joe Edit Update
Joe Edit Update
Perri Law LLP
7 Thrush Dr
Smithtown, NY 11787

Please do not respond to Perri Law LLP. Please direct any questions or responses to Recupera Record Services, Inc. 185 Great Neck Rd
Suite 403 Great Neck, NY 11021; Phone No.: (212) 580-1191; Fax No.: (212) 213-1715; Email: records@recuperars.com.

FILM REQUEST

Recupera No.: 3342

To: RECORDS CUSTODIAN
A Woman's Place
34 Sycamore Avenue, Suite 2A
Little Silver, NJ 07739

RECORDS/FILMS OF: Joe Smith

Your Tax Id No.: ____ (Necessary to issue check)

Please provide a quote as to what the cost of the reproduction of the films and/or disc reflected thereon would be. A complete breakdown is required prior to approval of duplication. If your office does not have radiology exams in your possession, please fill out the below accordingly.

________ No radiology exams done
________ No radiology exams due to being destroyed after _______ years.
________ No radiology exams in the office, but can be obtained from:
____
________ We have x-rays, MRIs, video fluoroscopes, CT scans and/or studies, films/disc, listed below.

Please complete the form and fax or mail to the address below prior to the compliance date specified on the Subpoena.

Film Date	View/Description	No. of Films	Duplicating Costs

Total Cost: ______________________________

____
CUSTODIAN NAME (PLEASE PRINT)

____
DEPARTMENT

____
SIGNATURE OF CUSTODIAN

____
DATE

SEND RECORDS AND INVOICE TO:
RECORDS@RECUPERARS.COM
OR
185 Great Neck Rd
Suite 403 Great Neck, NY 11021

Telephone # (212) 580-1191 - Fax # (212) 213-1715

Recupera # 3342

LOS ANGELES COUNTY SUPERIOR COURT-CIVIL/SMALL CLAIMS CIVIL DIVISION

Singh, Arjun
Plaintiff(s)
v.
Summit Medical Imaging, P.A.
Defendant(s)

Case No.: 2025-CV-024881

ACKNOWLEDGMENT AND WAIVER OF PERSONAL SERVICE OF SUBPOENA

(For document/records subpoenas served by mail under R. 1:9-3)

I, ____, acknowledge that I received by mail a subpoena in the above-captioned matter that seeks only the production of documents or records.

I hereby acknowledge receipt of the subpoena and waive personal service of that subpoena.

Date of receipt (if known): __________________________________

Signature: ____

Printed name / title: ____

Entity / Custodian (if applicable): ____________________________

Date signed: ____

Return this signed acknowledgment to:

Recupera Record Services, Inc.

185 Great Neck Rd
Suite 403

Great Neck, NY 11021

Email: records@recuperars.com   Fax: (212) 213-1715

Recupera # 3342

LOS ANGELES COUNTY SUPERIOR COURT-CIVIL/SMALL CLAIMS CIVIL DIVISION

Singh, Arjun
Plaintiff(s)
v.
Summit Medical Imaging, P.A.
Defendant(s)

Case No.: 2025-CV-024881

NOTICE OF SUBPOENA DUCES TECUM (DISCOVERY) (R. 4:14-7(c))

Under New Jersey Court Rule 4:14-7(c), a discovery subpoena commanding a person to produce evidence must be served on the witness and on all parties no less than ten (10) days prior to the records deposition / production date scheduled in the subpoena, and the subpoenaed evidence is not to be produced or released before that date.

YOU ARE NOTIFIED that the attached subpoena seeks records or other evidence from the non-party custodian(s) listed below.

Under New Jersey Court Rule 4:14-7(c), a discovery subpoena commanding a person to produce evidence must be served on the witness and on all parties no less than ten (10) days prior to the deposition date scheduled in the subpoena, and the subpoenaed evidence is not to be produced or released before that date.

If the custodian is notified that a motion to quash (or other motion/application) has been filed, the custodian should not produce or release the subpoenaed evidence unless ordered by the court or consented to in writing by all parties.

Advanced Healthcare and Chiropractic Center
11040 Santa Monica Blvd. Suite 480
Los Angeles, CA 90025
Medical, Billing and Films

1st Choice Pharmacy
2228 US Highway 19
Holiday, FL 34691
Medical, Billing and Films

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Accurate Monitoring, LLC
P.O. Box 75101
Chicago, IL 60675
Medical, Billing and Films

A Woman's Place
34 Sycamore Avenue, Suite 2A
Little Silver, NJ 07739
Medical, Billing and Films

Access Health Clinic
ATTN: Medical Records
400 Austin Street
Richmond, TX 77469
Medical, Billing and Films

ABC Dental Group
1319 North San Fernando Blvd.
Burbank, CA 91504
Medical and Billing

1100 Dental
100 South Broad Street
Trenton, NJ 08611
Medical and Billing

4G Advanced Spine & Outpatient Surgery Center
347 Mt Pleasant Ave
West Orange, NJ 07052
Medical and Billing

22 Area Branch Clinic
Bldg 22190 92056, Marine Dr
Oceanside, CA 92058
Billing and Films

AARP Membership Center
3200 East Carson Street
Lakewood, CA 90712
Medical and Billing

[Remainder of Page Left Intentionally Blank]

DATED this 2nd of February, 2026.

[Remainder of Page Left Intentionally Blank]

I HEREBY CERTIFY that a true and correct copy of the foregoing notice (with attached proposed subpoena(s)) was served on all parties/counsel of record on this 2nd of February, 2026 via e-service or other method permitted by applicable rules.

/s/ Joe Edit Update
Joe Edit Update
Perri Law LLP
7 Thrush Dr
Smithtown, NY 11787

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.