Recupera Record Retrieval Services LLC

185 Great Neck Rd

Great Neck, NY 11021

Tel: (212) 580-1191

## FACSIMILE TRANSMITAL SHEET

| | |
|---|---|
| TO:<br>Records Custodian | FROM:<br>Recupera Record Retrieval Services |
| COMPANY:<br>Cast & Crew | DATE:<br>April 17th, 2026 |
| PHONE NUMBER:<br>(212) 594-5686 | RECORDS OF:<br>David Thompson |
| FAX NUMBER:<br>(212)594-5762 | SENDER REFRENCE NUMBER:<br>7463 |

**RE:**

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

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

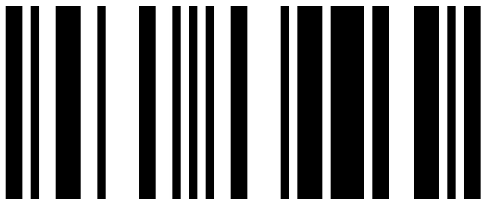
Thank You,

Recupera Record Retrieval Services LLC

Great Neck, NY 11021

Phone: (212) 580-1191

Fax: (212) 213-1715



Cast & Crew
7 Penn Plaza
New York, NY 10001

Recupera #: 7463

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:

Cast & Crew
7 Penn Plaza
New York, NY 10001

Please Find Enclosed a request for records of:

**PATIENT: David Thompson**
**DOB:**
**SSN:**

On behalf of Recupera Law, 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, Recupera Law, 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

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

Contact: Records Retrieval Department

Recupera Oder Number: 7463

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:<br>❑ At request of individual<br>❑ 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.**

RECUPERA
Record Retrieval Services

(212) 580-1191
info@recuperars.com
40 Wall Street, Suite 2855
New York, NY 10005

April 17th, 2026

To Whom It May Concern:

Please allow this correspondence to confirm that Recupera Law 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.

Very Truly Yours,

/s/ Bernard Arnault
**Bernard Arnault**
Recupera Law
185 Great Neck Rd
Great Neck, NY 11021

# CERTIFICATION OF SATISFACTORY ASSURANCE

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

PATIENT: David Thompson 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.

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_____ **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 David Thompson 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: (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.

__(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.

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**Bernard Arnault**
Name

April 17th, 2026
Date

**/s/ Bernard Arnault**
Signature

Recupera Law
Company