

**COMPOSITE**  
**EXHIBIT 6**  
**(File Under Seal)**

BOIES, SCHILLER & FLEXNER LLP

401 EAST LAS OLAS BOULEVARD • SUITE 1200 • FORT LAUDERDALE, FL 33301-2211 • PH. 954.356.0011 • FAX 954.356.0022

Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

March 8, 2016

Dr. Steven W. Olsen, M.D.  


**Re: *Virginia Giuffre***

Dear Dr. Olsen:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to our client. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

Enclosed is an authorization form executed by our client authorizing you to release this information to this Firm. Please forward all documents to my attention at Boies, Schiller & Flexner LLP, 401 East Las Olas Boulevard, Suite 1200, Fort Lauderdale, FL 33301.

We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,

  
Sigrid S. McCawley

SSM/ep  
Enclosure

### Authorization to Disclose Protected Health Information

Name: Virginia Roberts, Virginia Giuffre  
Address: \_\_\_\_\_  
Date of Birth: [REDACTED]  
Soc. Sec. #: \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Sigrid S. McCawley, Esq.  
Boies, Schiller & Flexner LLP  
401 E. Las Olas Blvd., Suite 1200, Ft. Lauderdale, FL 33301

3. Specific description of the information: Complete medical record from inception of treatment to present, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

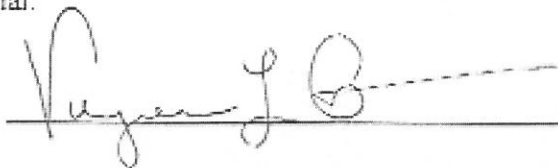
6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.

A handwritten signature in cursive script, appearing to read "Suzanne J. B.", is written over a horizontal line. A dashed line extends from the end of the signature to the right.

March 8th 2016  
Date

ORIGIN ID: HMOA (954) 356-0011 SIGRID MCCAWLEY BOIES, SCHILLER & FLEXNER LLP 401 E LAS OLAS BLVD., SUITE 1200 FORT LAUDERDALE, FL 33301 UNITED STATES US		SHIP DATE: 08MAR16 ACTWGT: 0.50 LB CAD: 1187925/NET3730 BILL SENDER	
TO <b>DR. STEVEN W. OLSEN, MD</b>			
			
TRK# 7758 2861 9430 0201		WED - 09 MAR 4:30P PRIORITY OVERNIGHT DSR 81212 CO-US COS	
			
J161016020501ur		540J1/CF34/727F	

**After printing this label:**

1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

**Warning:** Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.

Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on [fedex.com](http://fedex.com). FedEx will not be responsible for any claim in excess of \$100 per package, whether the result of loss, damage, delay, non-delivery, misdelivery, or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim. Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental, consequential, or special is limited to the greater of \$100 or the authorized declared value. Recovery cannot exceed actual documented loss. Maximum for items of extraordinary value is \$1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

BOIES, SCHILLER & FLEXNER LLP

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Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

March 28, 2016

Dr. Mona Devanesan, M.D.  


**Re: *Virginia Roberts Giuffre***

Dear Dr. Devanesan:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to Virginia Roberts. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

Enclosed is an authorization form executed by our client authorizing you to release this information to this Firm. Please forward all documents to my attention at Boies, Schiller & Flexner LLP, 401 East Las Olas Boulevard, Suite 1200, Fort Lauderdale, FL 33301.

We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,



Sigrid S. McCawley

SSM/ep  
Enclosure



### Authorization to Disclose Protected Health Information

Name: Virginia Roberts, Virginia Giuffre  
Address: \_\_\_\_\_  
Date of Birth: [REDACTED]  
Soc. Sec. #: \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Sigrid S. McCawley, Esq.  
Boies, Schiller & Flexner LLP  
401 E. Las Olas Blvd., Suite 1200, Ft. Lauderdale, FL 33301

3. Specific description of the information: Complete medical record from inception of treatment to present, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.

Raymond J. B.

March 8<sup>th</sup> 2016  
Date



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Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

April 5, 2016

Dr. Chris Donohue



**Re: *Virginia Giuffre/Virginia Roberts***

Dear Dr. Donohue:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to our client. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

Enclosed is an authorization form executed by our client authorizing you to release this information to this Firm. Please forward all documents to me in the enclosed FedEx return envelope provided for your convenience.

We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Sigrid S. McCawley', written over a horizontal line.

Sigrid S. McCawley

SSM/dk  
Enclosures

### Authorization to Disclose Protected Health Information

Name: Virginia Roberts, Virginia Giuffre  
Address: \_\_\_\_\_  
Date of Birth: [REDACTED]  
Soc. Sec. #: \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Sigrid S. McCawley, Esq.  
Boies, Schiller & Flexner LLP  
401 E. Las Olas Blvd., Suite 1200, Ft. Lauderdale, FL 33301

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4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

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8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.

\_\_\_\_\_

March 8<sup>th</sup> 2016  
Date

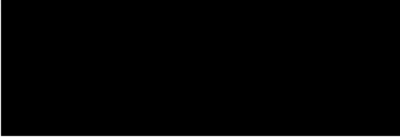
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Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

April 5, 2016

Dr. Harris



**Re: *Virginia Giuffre/Virginia Roberts***

Dear Dr. Harris:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to our client. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

Enclosed is an authorization form executed by our client authorizing you to release this information to this Firm. Please forward all documents to me in the enclosed FedEx return envelope provided for your convenience.

We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sigrid S. McCawley', written over a horizontal line.

Sigrid S. McCawley

SSM/dk  
Enclosures

### Authorization to Disclose Protected Health Information

Name: Virginia Roberts, Virginia Giuffre  
Address: \_\_\_\_\_  
Date of Birth: [REDACTED]  
Soc. Sec. #: \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Sigrid S. McCawley, Esq.  
Boies, Schiller & Flexner LLP  
401 E. Las Olas Blvd., Suite 1200, Ft. Lauderdale, FL 33301

3. Specific description of the information: Complete medical record from inception of treatment to present, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.



March 8<sup>th</sup> 2016  
Date



BOIES, SCHILLER & FLEXNER LLP

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Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

April 5, 2016

Dr. Sellathurai



**Re: *Virginia Giuffre/Virginia Roberts***

Dear Dr. Sellathurai:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to our client. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

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We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sigrid' followed by a stylized surname.

Sigrid S. McCawley

SSM/dk  
Enclosures

### Authorization to Disclose Protected Health Information

Name: Virginia Roberts, Virginia Giuffre  
Address: \_\_\_\_\_  
Date of Birth: [REDACTED]  
Soc. Sec. # \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Sigrid S. McCawley, Esq.  
Boies, Schiller & Flexner LLP  
401 E. Las Olas Blvd., Suite 1200, Ft. Lauderdale, FL 33301

3. Specific description of the information: Complete medical record from inception of treatment to present, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.



March 8, 2016  
Date

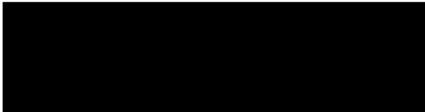
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Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

April 5, 2016

Dr. Wah Wah



**Re: *Virginia Giuffre/Virginia Roberts***

Dear Dr. Wah Wah:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to our client. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

Enclosed is an authorization form executed by our client authorizing you to release this information to this Firm. Please forward all documents to me in the enclosed FedEx return envelope provided for your convenience.

We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,

A handwritten signature in black ink, appearing to read 'SMC', with a long horizontal line extending to the right.

Sigrid S. McCawley

SSM/dk  
Enclosures

### Authorization to Disclose Protected Health Information

Name: Virginia Roberts, Virginia Giuffre  
Address: \_\_\_\_\_  
Date of Birth: [REDACTED]  
Soc. Sec. # \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Sigrid S. McCawley, Esq.  
Boies, Schiller & Flexner LLP  
401 E. Las Olas Blvd., Suite 1200, Ft. Lauderdale, FL 33301

3. Specific description of the information: Complete medical record from inception of treatment to present, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it

8. I understand that I am entitled to receive a copy of this authorization

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.



March 8<sup>th</sup> 2016  
Date



BOIES, SCHILLER & FLEXNER LLP

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Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

April 5, 2016

Royal Oaks Medical Center  


Attn: Records Dept.

**Re: *Virginia Giuffre***

Dear Sir/Madam:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to our client. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

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We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,

  
Sigrid S. McCawley

SSM/dk  
Enclosures

### Authorization to Disclose Protected Health Information

Name: Virginia Roberts, Virginia Giuffre  
Address: \_\_\_\_\_  
Date of Birth: [REDACTED]  
Soc. Sec. #: \_\_\_\_\_

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Sigrid S. McCawley, Esq.  
Boies, Schiller & Flexner LLP  
401 E. Las Olas Blvd., Suite 1200, Ft. Lauderdale, FL 33301

3. Specific description of the information: Complete medical record from inception of treatment to present, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

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March 8, 2016  
Date

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Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

April 28, 2016

Dr. Carol Hayek, M.D.  


**Re: *Virginia Roberts Giuffre***

Dear Dr. Hayek:

This Firm represents the above-named individual. Please provide us with all medical records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to Virginia Roberts Giuffre. Please make sure to include records detailing our client's current medication/prescriptions.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

Enclosed is an authorization form executed by our client authorizing you to release this information to this Firm. Please forward all documents to my attention at Boies, Schiller & Flexner LLP, 401 East Las Olas Boulevard, Suite 1200, Fort Lauderdale, FL 33301.

We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,



Sigrid S. McCawley

SSM/ep  
Enclosure

### **Authorization to Disclose Protected Health Information**

Name: Virginia Giuffre

Address:

Date of Birth:

Soc. Sec. #



I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

**Dr. Carol Hayek**

2. Specific person/organization (or class of persons) authorized to receive and use the information:

**Sigrid McCawley  
Boies, Schiller & Flexner LLP  
401 East Las Olas Blvd., Suite 1200  
Fort Lauderdale, FL 33301**

3. Specific description of the information: **Medical records from 1999 to the present**, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

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5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

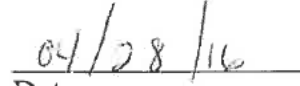
7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.

  
Signature

  
Date



BOIES, SCHILLER & FLEXNER LLP

401 EAST LAS OLAS BOULEVARD • SUITE 1200 • FORT LAUDERDALE, FL 33301-2211 • PH. 954.356.0011 • FAX 954.356.0022

Sigrid S. McCawley, Esq.  
Email: [smccawley@bsfllp.com](mailto:smccawley@bsfllp.com)

May 4, 2016

**Via Federal Express**

Judith Lightfoot

**Re: *Virginia Roberts Giuffre***

Dear Ms. Lightfoot:

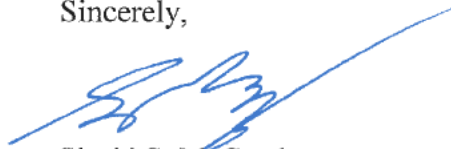
This Firm represents the above-named individual. It is my understanding that you are a psychologist that has counselled my client, Virginia Giuffre via telephone. Please provide us with all treating records, including, but limited to, progress notes, reports of tests and test results, billing information, and patient files pertaining to Virginia Roberts Giuffre.

Please advise me if there are any fees for copying her records. In addition, it is necessary that we receive records and reports as soon as possible.

Enclosed is an authorization form executed by our client authorizing you to release this information to this Firm. Please forward all documents to my attention at Boies, Schiller & Flexner LLP, 401 East Las Olas Boulevard, Suite 1200, Fort Lauderdale, FL 33301.

We appreciate your cooperation in this matter. If you have any questions, please contact me at 954-356-0011.

Sincerely,



Sigrid S. McCawley

SSM/ep  
Enclosure

### Authorization to Disclose Protected Health Information

Name: Virginia Giuffre

Address:

Date of Birth:

Soc. Sec. #

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

**Judith Lightfoot**

2. Specific person/organization (or class of persons) authorized to receive and use the information:

**Sigrid McCawley  
Boies, Schiller & Flexner LLP  
401 East Las Olas Blvd., Suite 1200  
Fort Lauderdale, FL 33301**

3. Specific description of the information: **Medical records from 1999 to the present**, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

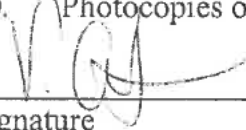
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\_\_\_\_\_  
Signature

5/2/16  
\_\_\_\_\_  
Date

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
\*\*\*\*\*

TRANSMISSION OK

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RECIPIENT ADDRESS	17192852030
DESTINATION ID	
ST. TIME	05/23 09:02
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## BOIES, SCHILLER & FLEXNER LLP

New York ■ Washington DC ■ Florida ■ New Hampshire ■ California ■ New Jersey ■ Nevada

401 East Las Olas Boulevard, Suite 1200

Fort Lauderdale, Florida 33301

Telephone: (954) 356-0011

Fax: (954) 356-0022

## FACSIMILE COVER SHEET

**TO:** Centura Health Medical Records **FAX: 719-285-2030**  
St. Thomas More Hospital  
Canon City, CO **TELEPHONE: 719-285-2000**

**FROM:** Meredith Schultz

**DATE:** May 23, 2016

Total Number of Pages:  
(INCLUDING THIS COVER SHEET): 2

**RE:** Patient Authorization to Disclose Protected Health Information

**MESSAGE:** Please see attached Patient Authorization to Disclose Protected Health Information. Per the attached form, please fax all records to 954-356-0022 to the attention of Meredith Schultz.

**BOIES, SCHILLER & FLEXNER LLP**

New York ■ Washington DC ■ Florida ■ New Hampshire ■ California ■ New Jersey ■ Nevada

401 East Las Olas Boulevard, Suite 1200

Fort Lauderdale, Florida 33301

Telephone: (954) 356-0011

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**THE ATTORNEY-CLIENT AND/OR ATTORNEY WORK-PRODUCT PRIVILEGES**

This facsimile transmission is intended solely for the above-named recipient and may contain confidential information which is exempt from disclosure and protected by the attorney-client and/or attorney work-product privileges. Any unauthorized use or disclosure is strictly prohibited and may result in civil and/or criminal liability. If any of the information contained in this transmission is misdirected to you, please call (954) 356-0011 collect and mail such information back to us. Thank you.

