EXHIBIT "B"

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS
----------X
ROY DAVE DAVIS, ANSCHERLEY NOEL,

Plaintiffs,

-against-

SORIN DANCU, JOSEPH S. DANCU,

Defendants,
----------X

PLAINTIFF'S REPLY TO COMPLIANCE CONFERENCE ORDER

Index#: 513649/2016

Plaintiff, ROY DAVE DAVIS, by his attorneys, GREGORY SPEKTOR AND ASSOCIATES, P.C., responding to Compliance Conference Order, dated June 26, 2017 alleges, upon information and belief, as follows;

As to Plaintiff ROY DAVE DAVIS:

1. Respond to Post EBT Demands for Discovery along with HIPAA Authorizations were provided to your office on July 5th, 2017.
2. Trial Authorizations for all providers are annexed hereto.

Dated: Rosedale, NY
July 7th, 2017

Yours, etc.
GREGORY SPEKTOR AND ASSOCIATES, P.C.
Attorney for Plaintiffs
ROY DAVE DAVIS, ANSCHERLEY NOEL
One Cross Island Plaza, Suite 203C
Rosedale, NY 11422
(718) 528-5272

To:

JAMES G. BILELLO & ASSOCIATES
Attorneys for Defendant(s)
SORIN DANCU,
JOSEPH S. DANCU.
100 Duffy Avenue, Suite 500
Hicksville, NY 11801
516-861-1830

AFFIDAVIT OF SERVICE

STATE OF NEW YORK)

COUNTY OF QUEENS) ss.

Dmitry Fayzullaev being duly sworn deposes and says:

I am over 18 years of age, I am not a party to the action, and I reside in Queens County in the State of New York.

I served a true copy of the annexed:

PLAINTIFF'S REPLY TO COMPLIANCE CONFERENCE ORDER

On 7 **day of** July, **2017**

by mailing the same in a sealed envelope, with postage prepaid thereon, in a post office or official depository of the U.S. Postal Service within the State of New York, addressed to the last known address of the addressee as indicated below:

JAMES G. BILELLO & ASSOCIATES
Attorneys for Defendant(s)
SORIN DANCU,
JOSEPH S. DANCU.
100 Duffy Avenue, Suite 500
Hicksville, NY 11801
516-861-1830

Sworn to before me
On 7 day July, 2017

Notary Public

OKSANA STETSKA
NOTARY PUBLIC STATE OF NEW YORK
WESTCHESTER COUNTY
LIC. # 01ST6358193
COMM. EXP. May 8, 2021

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
Roy Dave Davis	[redacted]	[redacted]
Patient Address		
[redacted] Street, Elmont, NY 11003		

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:
Lumper Inc c/o: P.O Box 2845, Clinton, IA 52733

8. Name and address of person(s) or category of person to whom this information will be sent:
Kings County Supreme Court: Subpoena Records Room 360 Adams Street Brooklyn, N.Y 11201

9(a). Specific information to be released:

- ☑ Medical Record from (insert date) 7-13-2015 to (insert date) Present
- ☑ 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: NF Rle: claim # C-015-8821-NY15

Include: (*Indicate by Initialing*)

____ **Alcohol/Drug Treatment**
____ **Mental Health Information**
____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here ____ (Initials) I authorize _____ (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:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: litigation	at the end of litigation
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.

Roy Davis Date: 3/2/18

Signature of patient or representative authorized by law

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