MEMORANDUM ENDORSEMENT

Edwards v. Daniels, et al.,
17 CV 5018 (VB)

In the attached letter-motion dated January 17, 2020, defense counsel requests the Court compel plaintiff, who is proceeding pro se and in forma pauperis, to complete and return a HIPAA authorization form. (Doc. #151). On October 17, 2019, defense counsel mailed the authorization form to plaintiff. According to defense counsel, plaintiff has not returned the completed form.

Defense counsel contends records of plaintiff's medical treatment while in DOCCS custody are needed to assess plaintiff's claims for emotional distress and psychological illness. Defense counsel further states that during his deposition, plaintiff testified to his psychological condition and medications he takes as a result of an alleged use of excessive force incident, which is the subject of the instant case.

The Court defers ruling on defense counsel's letter motion. Rather, if plaintiff appears for the case management conference scheduled for February 6, 2020, at 9:30 a.m., the Court will address the motion at that time.

However, it appears the Court's December 27, 2019, Order (Doc. #149), which was mailed to plaintiff, was returned as undeliverable. The December 27 Order instructed plaintiff to update the Court in writing as to his current address, and warned plaintiff, in bold and underlined font, that failure to do so may result in dismissal of this case. (Id.).

In view of plaintiff's pro se status, the Court sua sponte extends to February 4, 2020, plaintiff's time to notify the Court in writing as to his current address. **If plaintiff fails to update his address by February 4, 2020, and appear for the February 6, 2020, case management conference, the Court will dismiss the case for failure to prosecute or comply with court orders. Fed. R. Civ. P. 41(b).**

The Clerk is directed to mail copies of the Court's December 27 Order (Doc. #149) and this Order to plaintiff at the following address provided by plaintiff during the December 6, 2019, case management conference:

William L. Edwards
881 East 162nd Street
Apartment 1E
Bronx, NY 10459

The Court certifies pursuant to 28 U.S.C. § 1915(a)(3) that any appeal from this Order would not be taken in good faith, and therefore in forma pauperis status is denied for the purpose of an appeal. See Coppedge v. United States, 369 U.S. 438, 444–45 (1962).

Dated: January 21, 2020
White Plains, NY

SO ORDERED:

Vincent L. Briccetti
United States District Judge

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

LETITIA JAMES
ATTORNEY GENERAL

DIVISION OF REGIONAL OFFICES
WESTCHESTER REGIONAL OFFICE

January 17, 2020

Hon. Vincent L. Briccetti
United States District Court
300 Quarropas Street
White Plains NY 10601

Re: Edwards v. Argibay et al., 17-cv-5018 (VB)

Dear Hon. J. Briccetti:

In this action, this Office represents the remaining Defendants in this action. This is a letter motion asking the court to compel Plaintiff to complete and return the HIPAA authorization sent to Plaintiff on 10/17/2019, a copy is attached.

As stated in Defendant's letter, at Plaintiff's deposition, Plaintiff testified to several psychological medications and conditions that he seeks to attribute Defendants. Defendants forwarded a HIPAA to allow Defendants to obtain Plaintiff's records from the New York State Office of Mental Health (OMH) for Plaintiff's care while in DOCCS custody. Defendants also enclosed a self-addressed stamped envelope returnable to this Office.

Plaintiff failed to return the completed HIPAA in the enclosed envelope to this Office. However, he claims emotional distress and psychological illness due to the alleged use of force. Defendants respectfully request that Plaintiff be compelled to return the same.

Respectfully,

J. Powers

J. Powers, AAG

cc: William L. Edwards 881 East 162nd Street, Apartment 1E, Bronx, NY 10459

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

LETITIA JAMES
ATTORNEY GENERAL

DIVISION OF REGIONAL OFFICES
WESTCHESTER REGIONAL OFFICE

October 1, 2019

William L. Edwards
Inmate DIN: 14-A-2670
Fishkill Correctional Facility
P.O. Box 1245
Beacon, NY 12508

Re: Edwards v. Argibay et al., 17-cv-5018 (VB)

Dear Mr. Edwards:

At your deposition, you testified to several psychological medications and conditions that you seek to attribute to the allegations in your Complaint. As mentioned at your deposition, I am now forwarding to you a HIPAA to allow me to obtain your records from the New York State Office of Mental Health (OMH) for your care while in DOCCS custody.

Fill out the highlighted areas and sign where indicated. Return the completed HIPAA in the enclosed envelope to this Office.

Regards,

JP.
Janice Powers

Enclosure: OMH HIPAA

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
William L. Edwards (DIN: 14-A-2670)	**10/26/1972**	
Patient Address		
NYS DOCCS Fishkill Correctional Facility P.O. Box 1245 Beacon NY 12508		

enter your ssn here

I, or my authorized representative, request that health information regarding my care and treatment be

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and (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:
NYS OFFICE OF MENTAL HEALTH

8. Name and address of person(s) or category of person to whom this information will be sent:
NYS ATTORNEY GENERAL 44 S. Broadway White Plains, NY 10601

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 _____ (Initials) I authorize **NYS OFFICE OF MENTAL** (Name of indiv

to discuss my health information with my attorney, or a governmental agency, lis

NEW YORK STATE OFFICE OF THE ATTORNEY GENERAL
(Attorney/Firm Name or Governmental Agency Name)

place initials here

_____

_____

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☑ Other: **Lawsuit initiated by William Edwards**	**at resolution of lawsuit**
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.

sign here

date here

* **Human Immunodeficiency Virus that causes AIDS identify someone as having HIV symptoms or infe**

aw protects information which reasonably could on's contacts.

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

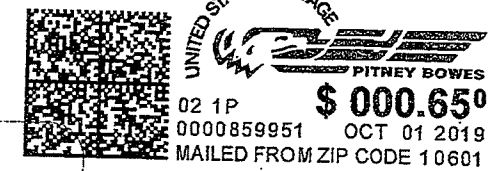
This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal 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.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
WESTCHESTER REGIONAL OFFICE
44 SOUTH BROADWAY
WHITE PLAINS, NY 10601



William L. Edwards
DIN: 14-A-2670
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LEGAL MAIL