

EXHIBIT 1
(File Under Seal)

Authorization to Disclose Protected Health Information

Name: Virginia Giuffre

Address: [REDACTED]

Date of Birth: [REDACTED]

Soc. Sec. #: [REDACTED]

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.

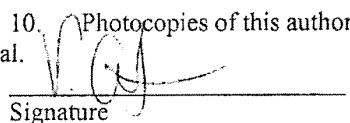
6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

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

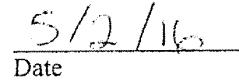
8. I understand that I am entitled to receive a copy of this authorization.

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

EXHIBIT 2
(File Under Seal)

Meredith Schultz

From: Bernadette Martin <bernadette@mbe-accounting.com.au>
Sent: Monday, June 27, 2016 10:33 PM
To: Meredith Schultz
Subject: Virginia Giuffre

Dear Sir/Madam

Ms Judith A Lightfoot has requested I forward this to you:

This will serve to advise all records of a psychological nature have been presented.
Judith A Lightfoot
Consulting Psychologist
28 June 2016

Kind Regards

Bernadette Martin

Ph: 02 43533630
Fax: 02 43533629
Bernadette@mbe-accounting.com.au



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TUGGERAH 2259
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