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

March 8, 2016

Dr. Steven W. Olsen, M.D.
[redacted]

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.

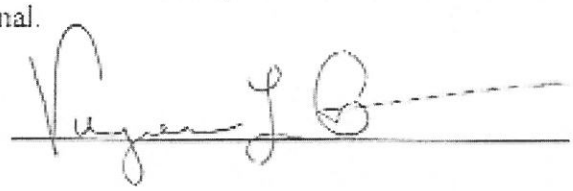
6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

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.



March 8th 2016
Date

After printing this label:
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Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on 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

March 28, 2016

Dr. Mona Devanesan, M.D.
[redacted]

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.

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March 8th 2016
Date

BOIES, SCHILLER & FLEXNER LLP
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Sigrid S. McCawley, Esq.
Email: smccawley@bsfllp.com

April 5, 2016

Dr. Chris Donohue
[redacted]

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,

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.

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March 8th 2016
Date

BOIES, SCHILLER & FLEXNER LLP

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Sigrid S. McCawley, Esq.
Email: smccawley@bsfllp.com

April 5, 2016

Dr. Harris
[redacted]

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,

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.

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Sigrid S. McCawley, Esq.
Email: smccawley@bsfllp.com

April 5, 2016

Dr. Sellathurai
[redacted]

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,

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.

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March 8th 2016
Date

BOIES, SCHILLER & FLEXNER LLP

401 EAST LAS OLAS BOULEVARD • SUITE 1200 • FORT LAUDERDALE, FL 33301-2211 • PH. 954.356.001 • FAX 954.356.0022

Sigrid S. McCawley, Esq.
Email: smccawley@bsfllp.com

April 5, 2016

Dr. Wah Wah
[redacted]

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,

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.

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March 8th 2016
Date

BOIES, SCHILLER & FLEXNER LLP
401 EAST LAS OLAS BOULEVARD • SUITE 1200 • FORT LAUDERDALE, FL 33301-221 • PH. 954.356.0011 • FAX 954.356.0022

Sigrid S. McCawley, Esq.
Email: smccawley@bsfllp.com

April 5, 2016

Royal Oaks Medical Center
[redacted]

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.

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,

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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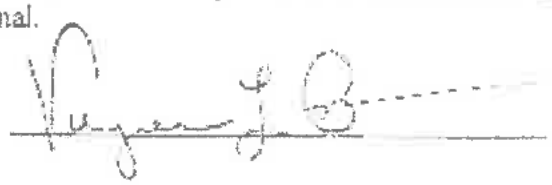

March 8th 2016
Date

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

April 28, 2016

Dr. Carol Hayek, M.D.
[redacted]

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: [redacted]
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.

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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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

04/28/16
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

May 4, 2016

Via Federal Express

Judith Lightfoot
[redacted]

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: [redacted]
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.

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

5/2/16
Date

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3024
RECIPIENT ADDRESS	17192852030
DESTINATION ID	
ST. TIME	05/23 09:02
TIME USE	01'34
PAGES SENT	2
RESULT	OK

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**
St. Thomas More Hospital
Canon City, CO

FAX: 719-285-2030
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
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Fort Lauderdale, Florida 33301
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