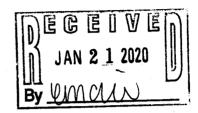
OFFICE OF INTERNAL AFFAIRS SOUTHERN REGION 9035 Haven Avenue, Suite 105 Rancho Cucamonga, CA 91730



January 9, 2020

George Soohoo 2506 Lighthouse Lane Corona Del Mar, CA 92625



Dear Mr. Soohoo:

The Office of Internal Affairs-Southern Region has referred the investigative report, case number S-CIM-255-18-A, to the appropriate departmental hiring authority.

We appreciate your cooperation and patience during the investigation. If you have any questions relative to this matter or any subsequent action by your hiring authority, please contact the Employee Relations Officer or hiring authority.

Sincerely,

DWAYNE DAVIDSON
Special Agent-In-Charge
Office of Internal Affairs-Southern Region

cc: Hiring Authority

PHILIP M. COHEN*
MARIANNE S. JOHNSON
DEBORAH A. HOLLINGSWORTH*#
MARISA R. QUINZII
*Certified Specialist, Workers' Compensation Law

#of-counsel

State Bar of California, Board of Legal Specialization

PHILIP M. COHEN

A PROFESSIONAL CORPORATION
1550 HOTEL CIRCLE NORTH, SUITE 170
SAN DIEGO, CALIFORNIA 92108

TELEPHONE:

(619) 297-5100

January 15, 2020

Via Email: tem-customerservice@ontellus.com Adrianna Payne / Client Service Specialist /Ontellus 27450 Ynez Road, Suite 300 Temecula, CA 92591-4680

Re:

George Soohoo v. State of California Department of Corrections

WCAB No.: ADJ11815610

Claim No.: 06380832

DOI: 08/01/2015 - 07/06/2018

Dear Ms. Payne:

Enclosed please find:

* 1/15/2020 Department of Veterans Affairs Request For and Auth to Release

You are authorized to utilize the enclosed authorization solely on the condition that you provide me with a complete copy of all writings you receive concurrently with your receipt of same and you provide a copy of all writings generated relative to these releases upon the generation of same.

If you have any questions or I can provide you further information, do not hesitate to contact me. I thank you for your courtesy and cooperation in handling this matter.

Sincerely,

LAW OFFICES OF PHILLIP M. COHEN, APC

Philip M. Cohen, Esq.

PMC/dp

Enclosure: As noted above

cc: George Soohoo, John C. Dunk

OMB Number: 2900-0260 Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL **RECORDS OR HEALTH INFORMATION**

Privacy Act and Paperwork Reduction Act Informations: The execution of this form does not sutherize the release of information expensed in this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Pertability and Assessme CPR Parts 160 and 164, 5 U.S.C. SSIn, and 38 U.S.C. S701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. Hencever, if including Social Scourity Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterana Affairs will not have the property of the request. The Veterana Health Administration may not on condition treatment, payment, enrollment or clightility on signing the authorization. VA may disclosure that you put on the form an permitted by low. VA may make a "restrict use" disclosure of the information as outlined in the Privacy Act systems of records notions identified "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You to not have to provide the information to VA, but if you don't, VA will be unable to request and serve your readical needs. Failure to familia the information will not have any affect on any other benefits to which you may be enabled. If you provide VA powers and horizontal or sequence by low. The Paperwork Reduction Act of 1995 requires us to mainly you that this information collection is in accordance with the cleanance is accion 3507 of the Paperwork Reduction Act of 1995, We may not conduct or expendent of the provide the sum makes 3 dispensed in account. We assisted the representation of the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.		
TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type same and address of health	PATIENT NAME (Lant, First, Mode)	-Mai)
core facility)	SOOHOO, GEORGE N	
VA LONG BEACH HEALTHCARE SYSTEM: 5901 E	SOCIAL SECURITY HEAVER	
7TH ST, LONG BEACH, CA 90822	562=76=4407	
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED		
ONTELLUS - 2/450 YNEZ RD #300, TEMECULA, CA 92591		
STATE FUND - RIVERSIDE - STATE CONTRACTS: PO BOX 65005, FRESNO, CA 93650-5005		
VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):		
IN DRUG ABUSE IN ALCOHOLISM OR ALCOHOL ABUSE IN TESTING FOR OR INFECTION WITH HUMAN SMALINODEFICIENCY VIRUS PRIVING SICKLE CIELL ANEMIA		
INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each) [E] COPY OF HOSPITAL SUMMARY [E] COPY OF OUTPATIENT TREATMENT NOTE(S) [T] OTHER (Specify)		
Any and all medical records		
PURPOSE(S) OR HEED FOR WHICH THE INFORMATION IS TO BE USED BY REDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED		
DISCOVERY OF WORKER'S COMPENSACION CASE		
NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM		
AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given showe is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorization for information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):		
Two (2) years from date signed		
[1]		
I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.		
DATE (mm/dd/yyy) SIGNATURE OF PAREON AUTHORIZED TO SIGN PATIENT (Allach sulhority to sign, e.g., POA) (Sign in Ink.)		
01-15-2020 were 11) wither		
FOR VICUSE ONLY		
IMPRINT PATIENT DATA CARD (or enter Name Address, Social Security Number) TYPE AND EXTENT OF MATERIAL RELEASED		
THE WAS SAIDLE OF MAINTAIN WINDOW WINDOWS COME CONTROL WINDOWS		
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