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,

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

cc: Hiring Authority

LAW OFFICES OF
PHILIP M. COHEN
A PROFESSIONAL CORPORATION
1550 HOTEL CIRCLE NORTH, SUITE 170
SAN DIEGO, CALIFORNIA 92108

PHILIP M. COHEN*
MARIANNE S. JOHNSON
DEBORAH A. HOLLINGSWORTH*#
MARISA R. QUINZII
*Certified Specialist, Workers' Compensation Law
State Bar of California, Board of Legal Specialization
#of-counsel

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 Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out 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 name and address of health care facility)

VA LONG BEACH HEALTHCARE SYSTEM: 5901 E 7TH ST, LONG BEACH, CA 90822

PATIENT NAME (Last, First, Middle Initial)

SOOHOO, GEORGE M

SOCIAL SECURITY NUMBER

562-78-4407

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

ONTELLUS - 27450 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):

[X] DRUG ABUSE [X] ALCOHOLISM OR ALCOHOL ABUSE [X] TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) [X] SICKLE CELL 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)

[X] COPY OF HOSPITAL SUMMARY [X] COPY OF OUTPATIENT TREATMENT NOTE(S) [ ] OTHER (Specify)

Any and all medical records

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Discovery of worker's compensation 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 above 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 authorized 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

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/yyyy): 01-15-2020

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM JUL 2013 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2006.