Henderson et al. v. Ciox Health, LLC et al.
Class Action Settlement
P.O. Box 2003
Chanhassen, MN 55317-2003

PROOF OF CLAIM AND RELEASE

Lynn Henderson, Espire Concepcion, Antonio Jones and Tyrone Green-Smith, individually and on behalf of all others similarly situated v. CIOX Health, LLC f/k/a HealthPort Technologies, LLC, SSM Health Care Corporation and SSM Regional Health Services
Case No. 1416-CV13765, pending in the Circuit Court of Jackson County, Missouri at Kansas City

If you are reviewing this Proof of Claim, you probably received and reviewed a "Notice of Pendency of Class Action and Proposed Settlement," which more fully explains this Action and the terms of the tentative settlement among the Parties therein. As set forth in the Notice, in order for you or your client/patient to be eligible to receive a settlement payment you must complete all required portions of this Proof of Claim and Release form on the Settlement Webpage: www.MOMedicalRecordsSettlement.com. This Proof of Claim must be completed, signed, and submitted electronically via the Settlement Webpage, **no later than July 13, 2021**. Please read the Notice and Settlement Agreement carefully before filling out this form. Capitalized terms are defined in the Settlement Agreement.

If you have any questions with regard to completing this Proof of Claim, you may email or write to Class Counsel: (i) Matthew L. Dameron, Williams Dirks Dameron LLC, 1100 Main Street, Suite 2600, Kansas City, Missouri 64105; (ii) M. Blake Heath, M. Blake Heath, Trial Attorney LLC, 917 West 43rd Street, Suite 100, Kansas City, Missouri; or (iii) William C. Kenney, Bill Kenney Law Firm, LLC,, 1100 Main Street Suite 1800, Kansas City, Missouri 64105. **Do not contact the Court, the Defendants or Defense Counsel for advice or information about this Settlement.**

It is your responsibility to make sure that your Proof(s) of Claim is timely received; the Parties and their attorneys cannot assume responsibility for Proof(s) of Claim that are not received. You should keep a copy of your completed **Proof(s) of Claim for your records. Proof(s) of Claim that do not comply with all requirements herein shall be deemed invalid.**

IMPORTANT INSTRUCTION: The "Claimant" in Section I below is the person to whom a settlement check will be mailed if the Proof of Claim is validated. Claimants may be a Patient or his/her personal representative, or any Non-Patient requestor. Only one settlement payment will be made for any particular Qualifying Request. In the event of a Claim by more than one individual or entity the Claims Administrator will determine who shall receive the payment.

Depending on the request for recovery submitted, Section II, or III must also be completed.

By signing this Proof of Claim and Release, the Claimant agrees to be bound by the terms and conditions of the Settlement Agreement.

***** EVERYONE MUST COMPLETE THIS SECTION*****

I. CLAIMANT INFORMATION

***Name (First and Last):** ______________________________

***Mailing Address:** ______________________________

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***City** ***State** ***Zip Code**

***Category of Claimant:**

☐ **Patient** ☐ **Attorney** ☐ **Professional Copy Service / Requestor Company** ☐ **Other**

***Last Four Digits of Patient's Social Security Number:** __________

Phone Number (*Daytime*): __________________ Phone Number (*Evening*): __________________

Phone Number (*Mobile*): __________________ Fax Number: __________________

***Email Address:** ______________________________

*** - Denotes Required Fields**

***** IF YOU ARE A NON-PATIENT (I.E., ATTORNEY, LAW FIRM, RECORDS REQUESTING COMPANY, PROFESSIONAL PARALEGAL, OR INSURANCE COMPANY) SEEKING RECOVERY FOR YOURSELF, PLEASE COMPLETE THIS SECTION *****

II. ATTORNEY / LAW FIRM / INSURANCE COMPANY / OTHER NON-PATIENT RECOVERY

I, ______________________________ [*NAME*] certify, under penalty of perjury, the following:

1. Between June 9, 2009 and **March 15, 2021**, I requested medical records from a Missouri Hospital, and:
   a. I was charged an E-Delivery Fee of **$**__________ by CIOX for those medical records and paid such E-Delivery Fee;
   b. I was charged a No Records Found Fee of **$**__________ by CIOX for those medical records and paid such No Records Found Fees; and/or
   c. I was charged a Notary Fee of **$**__________ by CIOX for those medical records and paid such Notary Fee.
2. I have not already been reimbursed by CIOX or any other party, either directly or indirectly, for the claims set forth in this Proof of Claim.
3. I have not already entered into a settlement for the claims set forth in this Proof of Claim.
4. I have not assigned my claims to any person or been reimbursed by any other person, and to my knowledge no other person has submitted a Proof of Claim related to this request or these fees.
5. I understand that claims may be audited for veracity and accuracy. I agree to provide in a timely manner any additional necessary information within my possession as requested by the Claims Administrator to validate my claim, and I understand that my claim may be rejected if I fail to respond to a request by the Claims Administrator for additional information.
6. If I am completing this form on behalf of a firm, I have full authority to bind the firm.

a. Patient Name: ______________________________

b. Hospital-or-provider: ______________________________

c. Invoice Number: ______________________________

d. Any reimbursement should be sent to the following address:

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Claimant may obtain a list of eligible invoices from the Claims Administrator to assist in completing this Claim Form.

☐ *By checking this box, I certify under penalty of perjury that I paid the amount(s) set forth above* ***and was not reimbursed by any person*** *(including but not limited to my client, an opposing party, or an insurance company).*

Signature: ________________________ Date Signed: ____________________

***** IF YOU ARE PATIENT / INDIVIDUAL SEEKING RECOVERY FOR YOURSELF, PLEASE COMPLETE THIS SECTION *****

III. PATIENT RECOVERY BY PATIENT

I, ________________________ [*NAME*] certify, under penalty of perjury, the following:

1. Between June 9, 2009 and **March 15, 2021**, I requested medical records from a Missouri Hospital, and:
   a. I was charged an E-Delivery Fee of **$**__________ by CIOX for those medical records and paid such E-Delivery Fee;
   b. I was charged a No Records Found Fee of **$**__________ by CIOX for those medical records and paid such No Records Found Fees; and/or
   c. I was charged a Notary Fee of **$**__________ by CIOX for those medical records and paid such Notary Fee.
2. I have not already been reimbursed by CIOX or any other party, either directly or indirectly, for the claims set forth in this Proof of Claim.
3. I have not already entered into a settlement for the claims set forth in this Proof of Claim.
4. I have not assigned my claims to any person or been reimbursed by any other person, and to my knowledge no other person has submitted a Proof of Claim related to this request or these fees.
5. I understand that claims may be audited for veracity and accuracy. I agree to provide in a timely manner any additional necessary information within my possession as requested by the Claims Administrator to validate my claim, and I understand that my claim may be rejected if I fail to respond to a request by the Claims Administrator for additional information.

a. Patient Name: ________________________

b. Name of Person who requested the Records: ________________________

c. Relationship to Patient: ________________________

d. Hospital: ________________________

e. Invoice Number: ________________________

f. Any reimbursement should be sent to me at the following address:

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Claimant may obtain a list of eligible invoices from the Claims Administrator to assist in completing this Claim Form.

☐ *By checking this box, I certify under penalty of perjury that I paid the amount(s) set forth above* ***and was not reimbursed by any person*** *(including but not limited to my lawyer, an opposing party, or an insurance company).*

Signature: ________________________ Date Signed: ____________________