UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

DENNIS LARAMORE,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 4:17-CV-1618 JAR
	)	
SHANNON THOMPSON, et al.,	)	
	)	
Defendants.	)	

MEMORANDUM AND ORDER

The Court is in receipt of Plaintiff's supplemental filing, which includes an inmate grievance form and an informal resolution request. (Doc. No. 47) To the extent Plaintiff is seeking to add a claim, he is advised that the Court does not allow amendments by interlineation and supplements. If Plaintiff wishes to amend his complaint, he must file a motion to amend and include a proposed pleading that includes each and every claim he wishes to bring. Plaintiff is cautioned that the filing of an amended pleading replaces the original, and claims that are not realleged are deemed abandoned. See Popoalii v. Correctional Medical Services, 512 F.3d 488, 497 (8th Cir. 2008).

Plaintiff has also moved for appointment of counsel. (Doc. No. 42) A review of the file indicates that Plaintiff first requested appointment of counsel on October 13, 2017. (Doc. No. 25) His request was considered in light of relevant factors, see Johnson v. Williams, 788 F.2d 1319, 1322-23 (8th Cir. 1986) and Nelson v. Redfield Lithograph Printing, 728 F.2d 1003, 1004 (8th Cir. 1984), and denied without prejudice on October 17, 2017. (Doc. No. 26) Upon consideration, the Court will deny Plaintiff's latest request for appointment of counsel. The Court finds nothing in the record to cause it to reconsider its previous order denying Plaintiff's

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motion for appointment of counsel. Again, this case is neither factually nor legally complex. Moreover, Plaintiff has demonstrated that he can adequately present his claims to the Court.

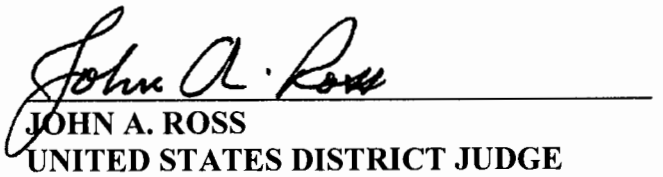
Lastly, with respect to Defendants' motion to compel (Doc. No. 32), the Court will direct Plaintiff to properly sign the attached medical authorization and provide Defendants with the original, signed authorization. In all other respects the Court finds that Plaintiff has made a good faith effort to comply with Defendants' discovery requests and denies Defendants' motion to compel without prejudice.

Accordingly,

IT IS HEREBY ORDERED that Defendants' Motion to Compel [32] is **DENIED** without prejudice.

IT IS FURTHER ORDERED that Plaintiff's Motion to Appoint Counsel [42] is **DENIED** without prejudice.

Dated this 11th day of April, 2018.



JOHN A. ROSS
UNITED STATES DISTRICT JUDGE

AUTHORIZATION FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the Blocks 1-7 must be completed. If any block is not completed then this "Authorization Form" will be considered incomplete and defective and cannot be used.

Block 1: Identification of Patient

PATIENT'S NAME: Dennis Lecamore DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

_____

SOCIAL SECURITY NUMBER or OTHER IDENTIFIER: (e.g. patient acct # or DL #) _____

Block 2: Type of Records/Information to be Disclosed – CHECK ONLY ONE OF THE FOLLOWING BOXES (A or B). If neither box is checked or if both boxes are checked then this form will be considered defective and cannot be used. IF YOU WANT BOTH TYPES OF RECORDS DISCLOSED YOU MUST USE TWO SEPARATE FORMS – One for Each Purpose.

☐ A. Records *except* for Psychotherapy Notes ☐ B. Psychotherapy Notes Only

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED (examples: All records, X-Rays only, records for last 12 months) &/OR CHECK ALL THAT APPLY: ☒ All Records* ☐ Alcohol/drug evaluation treatment ☐ HIV/Aids Status ☐ Pharmacy

_____

_____

LIST TREATMENT DATES IF KNOWN: _____

*All includes inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/Aids, pharmaceutical, hospital, or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices whether or not you created those records as long as the records are in your control or possession.

Block 3: Persons, facility, or class of persons who are authorized to disclose (provide) the records/information:

_____

Block 4: Persons, facility, or class of persons who are authorized to receive the records/information:

Paule, Camazine & Blumenthal, P.C., 165 N. Meramec, Suite 110, St. Louis, MO 63105

Block 5: Expiration: This "Authorization" will expire on _____ (MM/DD/YY) [In Kansas cannot exceed 1 year from date below] or on the following specific event: _____

Block 6: Purpose for which you want records/information disclosed: (*check one box*) ☐ At request of individual

OR ☐ Other: (*state reason*) _____

Block 7: Authorizing Signature – I authorize the disclosure of the records/information described and

- I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be redisclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law, including HIV, psychiatric or mental health treatment, alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation to the covered entity/healthcare provider authorized to disclose the records/information. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those prior actions.
- I know I may refuse to sign this form and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research or the reason for my treatment is to disclose information to another.
- I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this form.

_____ _____

Signature of Patient or Patient's Personal Representative Date of Signature

Personal Representative's Relationship/Capacity to Patient: _____

Printed Name of Personal Representative: _____

Address & telephone number of Personal Representative: _____

NOTE: If a Health Care Provider seeks an authorization from an individual for us or disclosure of protected health information, the Health Care Provider must provide a copy of this signed authorization to the individual.