Dear Editor,

I would like to submit the manuscript entitled "**Drug and herbal/dietary supplements -induced liver injury: a five year experience in a tertiary care center** " by Ayesha S. Siddique, Osama Siddique, Michael Einstein, Eva Urtasun-Sotil and Saverio Ligato to be considered for publication as "retrospective study".

Patients were not required to give consent to the study because the analysis used anonymous data that were obtained after each patient agreed to treatment by written consent.

Sincerely,

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Hartford HealthCare

HARTFORD HEALTHCARE CONSENT FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Patient Name Date of Birth: Medical Record Number

For the purposes of this form, Hartford Healthcare will include Hartford Hospital, Charlotte Hungerford Hospital, The Hospital of Central Connecticut, Midstate Medical Center, Natchaug Hospital, Rushford, The William Backus Hospital, Windham Hospital and Hartford Healthcare Medical Group.

Consent for Treatment and Authorization for Use and Disclosure of Protected Health Information: By signing this authorization form, I understand and agree that I am allowing disclosure of and access to all my health information, including, if applicable, information relating to alcohol and substance abuse/use, prescription information, mental or behavioral health, and HIV/AIDS. I hearby consent to diagnostic and treatment procedures and blood work, including but not limited to HIV testing that may be performed on me during my stay or visit at the hospital. These procedures are provided under the direction of my attending physician and other physicians involved in my care. I understand that I have the right to refuse to sign this consent. If I refuse to sign this consent, Hartford Healthcare may provide me with treatment as deemed necessary by a medical provider however; I will be responsible for charges incurred whether or not I sign this consent. I understand that many of the physicians practicing at the hospitals are not employees of the hospital; but rather, are independent contractors who as members of the hospital's medical staff utilize the hospital's facilities to treat patients. These independent contractors will bill me separately. I also understand that the use of the hospital lab coats, other clothing and identification badges by these independent contractors are not intended to lead anyone to believe that these persons are employees or agents of the hospital. I understand that nursing students and allied health trainees may be involved in my care under appropriate supervision. I understand and agree that audio, photographs, videotaped images or other images may be made of me for purposes of medical documentation or education as medical providers and staff deem appropriate.

I may be tested for HIV and that if I choose not to be tested I must communicate this fact to my physician. I authorize Hartford Healthcare to release such information for the purposes of my treatment or coordination between health care providers, discharge planning, research which doesn't use my identity, healthcare operations and payment by third-party payor(s). I authorize Hartford Healthcare to release my HIV information to an individual that has sustained a blood/body fluid exposure during the course of my care so that they may receive appropriate care and treatment.

Assignment of Benefits: I authorize payment directly to Hartford Healthcare or its designated billing agent as applicable and/or any attending physician or physician group for services rendered. I assign any insurance benefits and authorize payment, which I or the insured may be entitled to. I hereby appoint Hartford Healthcare as my agent to act on my behalf to collect claims for my hospital charges. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is accurate and complete. I authorize any holder of medical or other information about me to release such information to the Social Security Administration, its intermediaries or carriers, medical review boards and other organizations as necessary to administer the Medicare program. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable to physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Guarantee of Payment/Precertification by Insurer: I will be responsible for payment for all non-covered services. If my health plan does not consider Hartford Healthcare to be a participating provider, I will accept full financial responsibility for payment of incurred charges. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify carrier of services rendered according to the plan's provisions. Pursuant to Conn. Gen. Statutes Section 19a-509, all self pay patients may, upon request, receive a copy of hospital charges related to services provided to them.

Acknowledgement of Receipt of Notice of Privacy Practices: I have been offered and/or received a copy of The Hartford Healthcare Notice of Privacy Practices that describes how my protected health information may be used and disclosed. I understand that I am entitled to receive updates if Hartford Healthcare amends its Notice of Privacy Practices. Unless I object, I understand that Hartford Healthcare may disclose general information about me (name, location within facility and religious affiliation) from the facility directory to persons asking for me by name. Unless I object, Hartford Healthcare may also disclose protected health information of a general nature to my family or other individuals personally involved in my care, including changes in my condition.

Personal Valuables: I take full responsibility for retaining in my possession valuables, including but not limited to hearing aids, dentures, and eyeglasses that are not placed in the hospital safe. If I chose not to place valuables of any nature in the hospital safe, then the hospital will not be liable for loss or damage to any of these items.

Communications Via Cellular Phone and E-Mail: If I have provided a cellular telephone number as a contact number or an e-mail address as a contact, I hereby authorize Hartford Healthcare, along with its employees, agents, and business associates, to contact me via cellular phone or text message or e-mail for any reason, including, without limitation, automated notifications and appointment reminders.

I have the right to request that Hartford Healthcare restrict how it uses and/or discloses my protected health information for the purpose of providing treatment, obtaining payment and /or conducting healthcare operations. Hartford Healthcare is not required to agree to any restriction I request.

My signature below indicates I have read and understand the information listed above.

Patient or Legal Authorized Representative

Patient or Legal Authorized Representative Signature Date