IN RE: PELVIC MESH/GYNECARE LITIGATION

SUPERIOR COURT OF NEW JERSEY

LAW DIVISION: BERGEN COUNTY

FILED
FEB 05 2021
RACHEL L. HARZ
J.S.C.

CASE NO. 291
MASTER DOCKET NO.: BER-L-11575-14

CIVIL ACTION

CASE MANAGEMENT ORDER #67
Mixed Manufacturer Case Pool PFS/DFS Enabling Order
All prior orders remain in full force and effect except as modified by this Order.

THIS MATTER having been reassigned to the Bergen County Vicinage, from Atlantic County, pursuant to the Supreme Court's Order of October 31, 2014; the Court having conducted a Case Management Conference; counsel appearing; for good cause shown and for the reasons set forth on the record;

IT IS on this 5th day of ~~January~~ February, 2021, **ORDERED** as follows:

1. For all of the active cases[1] pending in this litigation that name defendant(s) in addition to or other than Ethicon, Inc. and Johnson & Johnson and their affiliates (collectively "Ethicon") "), except where the other defendant(s) is/are only C.R. Bard, Plaintiffs shall provide completed mixed-manufacturer Plaintiff Fact Sheets ("MMPFS", annexed hereto as Exhibit 1[2]) based on the number of cases being handled by the plaintiff's counsel, as follows:

    a. 10 or fewer cases = 45 days

[1] "Active Cases" shall refer to cases that the parties have agreed remain active as indicated on the spreadsheet of active mixed-manufacturer cases submitted to the Court in January 2021.

[2] Parties to these actions should take note that the MMPFS have defendant-specific form authorizations attached that must be completed as to each named defendant in the applicable case.

b. 20 or fewer cases = 60 days

c. 30 or fewer cases = 75 days

d. Greater than 30 cases = 90 days.[3]

2. Plaintiffs and their counsel shall make a good faith effort to serve the completed MMPFS on a rolling basis to avoid unnecessary burden on Defendants that would result if all MMPFS are served upon Defendants on the same or last day of the periods set forth in Paragraph 1, above.

3. Defendants shall produce completed mixed manufacturer Defendants' Fact Sheets ("MMDFS," annexed hereto as Exhibit 2) in response to materially completed corresponding MMPFS's reference in Paragraph 1, above, within 60 days of receipt; however Defendants are to make every effort to serve DFS sooner on a rolling basis whenever feasible.[4]

4. For all cases filed after the date of this Order that involve manufacturer defendants in addition to or other than Ethicon, except where the other defendant(s) is/are only C.R. Bard, Plaintiffs shall provide a completed MMPFS no later than 45 days after the date of filing their complaint, and Defendants (other than Ethicon) shall serve a completed MMDFS within 45 days of service of the completed MMPFS.

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[3] This Order contemplates that in compliance with prior Case Management Orders, including CMO No. 5 (PFS/Ethicon Defendants' DFS Enabling Order) entered on September 15, 2011, the majority of Plaintiffs implicated by this Order will already have produced a completed Ethicon PFS to Ethicon. If that is not the case, Plaintiff(s) need to comply with CMO 5 as to Ethicon. Plaintiffs also are required to update PFS forms with new information as required by existing CMOs and protocols.

[4] This Order contemplates that in compliance with prior Case Management Orders, including CMO No. 5 (PFS/Ethicon Defendants' DFS Enabling Order) entered on September 15, 2011, Ethicon will have already served an Ethicon DFS. If that is not the case, Ethicon is required to comply with CMO 5 as to Ethicon, and to update the DFS with new information as required by existing CMO's and protocols.

5. The parties have met and conferred and understand that the timing of service of MMPFS and the scope of certain information that may need to be gathered to complete the corresponding MMDFS may vary significantly. The parties have represented that they shall meet and confer and grant reasonable requests for extensions as needed, on a case-by-case basis.

6. Service of all MMPFS and MMDFS shall be made by email to the attorney(s) designated by Defendants, the designated Plaintiffs' Liaison Counsel, and the lead plaintiffs' counsel of record in the individual case, respectively. All MMPFS shall also be sent to the following email addresses: ColoplastPFS@kslaw.com; amsservice@reedsmith.com; mmcguire@tktrial.com; molly.gulbrandson@faegredrinker.com; MentorPFS@tuckerellis.com.

7. Associated document productions shall be made simultaneously via email or FTP upload (excluding DropBox).

8. Production of MMDFS shall not be delayed due to technical deficiencies in a MMPFS (e.g., missing telephone number, economic information to be supplied), but Plaintiffs understand that certain information must be supplied by Plaintiffs in the MMPFS in order for Defendants to provide a substantive response and Plaintiffs agree that the missing information, whether substantive or "technical," must be supplied within a reasonable time period after service of the deficient MMPFS.

9. Plaintiffs' liaison counsel (on behalf of all Plaintiffs' counsel) hereby consent to the disclosure of the individual names and law firms of all counsel

representing Plaintiffs in this litigation, in unredacted form, in adverse event reports that Defendants produce to Plaintiffs as part of the MMDFS response process. Plaintiffs' counsel (both liaison and non-liaison counsel) acknowledge and agree that no additional consent forms are necessary to authorize this disclosure. This paragraph shall be binding upon all counsel for Plaintiffs in pending and future-filed cases in this litigation. In the event that the reporting party of an adverse event is an attorney who does not represent a Plaintiff in this litigation, and the appropriate authorization cannot be obtained from that reporting attorney, then the adverse event report will be produced with only the name and identifying information of that reporting attorney redacted. Plaintiffs reserve the right to move at a later date for an unredacted copy of the adverse event report.

RACHELLE L. HARZ, J.S.C.

EXHIBIT A TO CMO 66

IN RE: PELVIC MESH/GYNECARE LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY CASE NO. 291 CT MASTER CASE 6341-10

PLAINTIFF FACT SHEET: MIXED-MANUFACTURER CASES

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses within a reasonable time if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure and as responses to requests for production pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure. The questions and requests for production contained in the Fact Sheet are non- objectionable and shall be answered without objection.

In filling out this form, please use the following definitions:

“Healthcare Provider” means any doctor, physician, surgeon, pharmacist, hospital, clinic, center, physician’s office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, any psychiatrist, psychologist, therapist, counselor, or other mental-health professional, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

"Pelvic Mesh Product(s)" refers to any pelvic mesh product manufactured by any Defendant, including American Medical Systems, Inc., Bard, Boston Scientific Corporation, Coloplast Corp., Mentor, or Ethicon, Inc., that was implanted in you.

"You" or "Your" refer to the person who received a Pelvic Mesh Product manufactured by any Defendant and who is identified in Question I. 1 (d) below.

To the extent that you have had more than one Pelvic Mesh Product implanted in you, please be specific in your response such that the response identifies which Pelvic Mesh Product is related to each part of each response.

To the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

I. BACKGROUND INFORMATION

1. Please state:

   a. Case caption: _____

   b. Docket number: _____

   c. Court in which case was originally filed: _____

   d. Full name of the person who received the Pelvic Mesh Product, including maiden name:

   _____

   e. Full name and address of the person completing this form, if different from the person listed in 1 (a) above, and the relationship of the person completing this form to the person listed in 1 (a) above:

   _____

   _____

   f. If completing this form in a representative capacity, please state whether you were appointed by a court, which court appointed you, and the date of your appointment:

   _____

   _____

   g. If you represent a decedent's estate, please state the date of the decedent's death:

   _____

   h. The name and address of the attorney representing you in this case: _____

   _____

2. Your Social Security Number: _____

3. Your date and place of birth: _____

4. Your current residence address: _____

   _____

5. Identify all individuals who currently live or have lived with you at your current address, their relationship to you, and the dates of residence. _____

   _____

   _____

6. If you have lived at your current address for less than 10 years, provide each of your prior residence addresses from 2000 to the present:

Prior Address	Dates You Lived At This Address	People Who Lived With You At This Address/ Relationship To You

7. Have you ever been married? **Yes___No _____**

If **Yes** provide the names and addresses of each spouse and the inclusive dates of your marriage to each person._____

_____

_____

8. Do you have children? **Yes___No _____**

If **Yes**, please provide the following information with respect to each child:

Full Name of Child	Date of Birth	Home Address (if different from yours)	Whether Biological/Adopted	Type of Delivery: Vaginal/C-Section

9. Have you had any pregnancies other than those that resulted in the births of your children identified above?

Yes___No_____ If **Yes**, provide the date and the outcome of each pregnancy:

_____

_____

10. Identify all secondary and post-secondary schools you attended, starting with high school and please provide the following information with respect to each:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

11. Please provide the following information for your employment history over the past 10 years:

Employer Name	Addresses	Job Title/ Description of Duties	Dates of Employment	Salary/Rate of Pay

12. Have you ever served in any branch of the military? **Yes** _____**No** _____

If **Yes**, please provide the following information:

a. Branch and dates of service; dates of your service, rank upon discharge and the type of discharge you received: _____

_____

b. Were you discharged from the military at any time for any reason relating to your medical, physical, or psychiatric condition? **Yes** _____**No** _____

If **Yes**, state what that condition was: _____

13. To the best of your knowledge, as an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? **Yes** _____**No** _____

If **Yes**, please set forth where, when and the felony and/or crime:

_____

_____

II. CLAIM INFORMATION

1) Do you claim to have been implanted with a Pelvic Mesh Product? **Yes** _____
No _____

If **Yes**:
a) Identify all Pelvic Mesh Product(s) that were implanted in you and provide the product code and lot number specific to that product, if known:

_____

b) Please give the date(s) that any Pelvic Mesh Product(s) were implanted in you:

_____

2) If you were implanted with an Ethicon Pelvic Mesh Product, please identify the type of product(s) that you received:

a) TVT: ____
b) TVT-O:_____
c) TVT-Secur:_____
d) Prolift Total: _____
e) Prolift Anterior:_____
f) Prolift Posterior:_____
g) TVT Exact
h) TVT Abbrevo
i) Prolift + M Total: _____

j) Prolift + M Anterior:_____
k) Prolift + M Posterior:_____
l) Prosima
m) Other: _____

3) If you were implanted with a Pelvic Mesh Product or Product(s) manufactured by a company other than Ethicon, Inc., please identify (i) each such Pelvic Mesh Product(s) and (ii) the Defendant manufacturer(s) of each such Pelvic Mesh Product(s):

_____

_____

_____

_____

4) Identify to the best of your knowledge the medical condition(s) and symptoms you were experiencing, that led to the implantation of the Pelvic Mesh Product(s) (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific as to the medical condition(s) and symptoms you were experiencing for each Pelvic Mesh Product): _____

_____

_____

_____

5) a) Give the name and address of the doctor who implanted the Pelvic Mesh Product(s) (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific for each):

_____

_____

b) Are you currently being treated by the surgeon(s) identified above?

Yes_____ **No** _____

If **No,** what was the date of your last visit or consultation with the surgeon(s)?

_____

6) To the best of your knowledge, were there any concurrent surgical procedures performed during the surgery in which the Pelvic Mesh Products were utilized? If so please identify the concurrent procedure(s) and the doctor(s) who performed them:

_____

_____

7) Give the name and address of the hospital or other healthcare facility where the Pelvic Mesh Product(s) was/were implanted (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific for each): _____

_____

8) Prior to implantation, did you receive any **written or verbal** information or instructions regarding the Pelvic Mesh Product(s), including any risks or complications that might be associated with the use of the product(s)? **Yes_____No ___**

If **Yes** (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific for each)**:**

a) Provide the date you received the information or instructions: _____

b) Identify by name and address the person(s) who provided the information or instructions: _____

_____

c) If you have copies of the written information or instructions you received, please attach copies to your response.

9) To the best of your knowledge, was any Pelvic Mesh Product(s) that was implanted in you ever removed, in whole or in part?

Yes _____ No _____ I Don't Know _____

If **Yes** (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific):

a) On what date, where and by whom (doctor) was the Pelvic Mesh Product(s), or any portion of it, removed? _____

_____

b) Explain why you consented to have the Pelvic Mesh Product(s), or any portion of it, removed?_____

_____

_____

_____

_____

c) To the best of your knowledge, does any medical treater, physician or anybody else on your behalf have possession of any portion of the Pelvic Mesh Product(s) that was previously implanted in you and removed?

_____

_____

10) To the best of your knowledge, if all or part of any Pelvic Mesh Product(s) remain implanted in you:

Has any doctor recommended removal of the remaining Pelvic Mesh Product(s)?

Yes ____No _____

If **Yes,** identify by name and address the doctor who recommended removal and state your understanding of why the doctor recommended removal:

_____

_____

11) Do you claim that you suffered bodily injuries as a result of any Pelvic Mesh Product(s)?

Yes _____No _____

If **Yes** (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific for each):

a) Describe the bodily injuries, conditions and/or symptoms that you claim resulted from the Pelvic Mesh Product(s)?

_____

_____

_____

_____

b) When is the first time you experienced bodily injuries, conditions and/or symptoms you have listed above that you now relate to the Pelvic Mesh Product(s)?

_____

_____

_____

c) For each bodily injury, condition and/or symptom you now claim to have experienced relating to any Pelvic Mesh Product(s), please state approximately when you first saw a Healthcare Provider for each of those bodily injuries, name of provider and diagnosis, if any, provided:

_____

_____

_____

d) Are you currently experiencing symptoms that you relate to your claimed bodily injuries?

Yes _____No _____

If **Yes**, please describe your current symptoms in detail:

_____

_____

_____

_____

e) Are you currently seeing, or have you ever seen any Healthcare Provider for any of the bodily injuries, conditions and/or symptoms listed above?

Yes _____No _____

If **Yes,** please list all Healthcare Providers you have seen for treatment of any of the bodily injuries you have listed above.

Provider Name and Address	**Condition Treated**	**Approximate Dates of Treatment**

f) Were you hospitalized at any time for the bodily injuries, conditions and/or

symptoms you listed above?

Yes _____No _____ If **Yes**, please provide the following:

Hospital Name and Address	Condition Treated	Approximate Dates of Treatment

12) To the best of your knowledge, have you been diagnosed with or treated for the following:

a) Vaginal Prolapse: Yes_____ No_____

b) Uterine Prolapse: Yes_____ No_____

c) Rectocele: Yes_____ No_____

d) Cystocele: Yes_____ No_____

e) Enterocele: Yes_____ No_____

f) Urinary incontinence: Yes_____ No_____

g) Fecal Incontinence: Yes_____ No_____

h) Urethral Hypermobility: Yes_____ No_____

If **Yes**, to (a)-(h) above identify the doctor who communicated the diagnosis, the date of the diagnosis, and the course of treatment recommended:

_____

_____

_____

13) Are you making a claim for lost wages or lost earning capacity?

Yes _____ **No**_____ If **Yes**, please answer the following (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific for each):

a) State the annual gross income you derived from your employment for each year, beginning five years prior to your surgery until the present:

_____

_____

_____

14) Are you making a claim for lost out-of-pocket expenses?

Yes _____ **No** _____If **Yes**, please identify and itemize all out-of-pocket expenses you have incurred (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific for each)**:**

_____

_____

15) Are you claiming mental and/or emotional damages?

Yes _____ **No** _____ If **Yes**, what mental and/or emotional damages do you claim

and what do you attribute them to?

_____

_____

If you are claiming mental and/or emotional damages, provide the following information for each Healthcare Provider (including but not limited to primary care physicians, psychiatrist, psychologists, therapists, and/or counselors) from whom you have sought treatment for your psychological, psychiatric or emotional conditions at any time:

Name	Address	Condition treated	Dates treated	Medications Prescribed

16) Has anyone filed a loss of consortium claim in connection with your lawsuit regarding the Pelvic Mesh Product(s)?

Yes _____No _____

If **Yes:** Identify by name and address the person who filed the loss of consortium claim, and state the relationship of that person to you: _____

_____

17) Have you or anyone acting on your behalf, other than your attorneys, had any communication, oral or written, with any of the Defendants or their representatives?

Yes _____No _____I Don't Know _____

If **Yes**, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any Defendants or their representatives:

_____

_____

_____

III. MEDICAL BACKGROUND

1) Provide your current age:_____Height_____Weight _____

2) At the time you received each Pelvic Mesh Product(s), please state:

Your age_____Your approximate weight _____

3) In chronological order, list any and all surgeries or hospitalizations you had **BEFORE** implantation of your first Pelvic Mesh Product(s) for treatment of a gynecological, urological, abdominal and/or colo-rectal condition, excluding child births. Identify by name and address the doctor(s), hospital(s) or other Healthcare Provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate. Date	**Description/Reason for Surgery or Hospitalization**	**Doctor or Healthcare Provider Involved (including address)**

[Attach additional sheets as necessary to provide the same information for any and all surgeries leading up to implantation of your first Pelvic Mesh Product(s)]

4) In chronological order, list any and all surgeries or hospitalizations you had **AFTER** the implantation of your first Pelvic Mesh Product(s) for treatment of a gynecological, urological, abdominal, colo-rectal and/or mesh-related condition, excluding child births. Identifying by name and address the doctor(s), hospital(s) or other Healthcare Provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date	**Description of Surgery/ Hospitalization**	**Doctor or Healthcare Provider Involved (including address)**

5) To the extent not already provided in the charts above, provide the name, address, and telephone number of any internal or family doctor, surgeon, hospital, or other Healthcare Provider from which you have received medical advice and/or treatment for the past **10 years**:

Name and Specialty	**Address**	**Approximate Dates/Years of Visits**

6) To the best of your knowledge, have you ever been diagnosed by a doctor or another Healthcare Providerwith any of the following:

Condition	Yes	No
Bleeding or clotting disorders		
Cancer		
Chronic obstructive pulmonary disease/COPD/chronic lung disease/Chronic coughing		
Complications related to childbirth		
Crohn's Disease, Irritable Bowel Syndrome, Ulcerative Colitis, Chronic Diarrhea or disease of the gut, intestines, or bowel		
Connective Tissue Disorder		
Diabetes		
Diverticulitis		
Fibromyalgia		
Fistula		
Hernia		
Interstitial Cystitis		
Malnutrition		
Obesity		
Pelvic Tumors or Fibroids		
Peripheral vascular disease or peripheral arterial disease		
Psychological/Mental/Emotional Conditions		
Recurrent constipation		

7) For each condition for which you answered **Yes** in the previous chart, or otherwise identified above, please provide the information requested below (attach additional sheets as needed):

Condition You Experienced	Date of Onset	Medication/Treatment	Treating Physician	Current Status of Condition

8) Have you experienced menopause? **Yes** _____**No** _____

If **Yes**, at what age did it begin? _____

9) Have you undergone vaginal estrogen therapy, hormone therapy, or systemic estrogen replacement therapy (ERT)? **Yes** _____**No** _____

If **Yes**,

a) Were you receiving vaginal estrogen therapy, hormone therapy, or systemic estrogen replacement therapy at the time of your implantation surgery?

Yes _____ **No** _____

b) Please provide the type of therapy you received, date(s) of the therapy, and the name and address of the Healthcare Providerproviding the therapy.

_____

_____

10) Have you received a hysterectomy? If so please state the doctors' name, city and state and date.

_____

_____

11) Do you now or have you ever smoked tobacco products? **Yes** _____ **No** _____

If **Yes**:

a) Provide the dates you smoked?

_____

b) How much do/did you smoke?

_____

12) Other than the implantation of the Pelvic Mesh Product(s) that are the subject of your lawsuit, have you had implanted inside of your body any other medical product of any kind, whether a mesh product or other device? **Yes** _____ **No** _____

If **Yes**, please provide the following information:

a) Product Name: _____

b) Date of Procedure Placing it and name and address of Healthcare Provider who placed it:

_____

c) Condition sought to be treated through placement of the device:

_____

d) Any complications you encountered with the medical product or procedure:

_____

e) Does that product remain implanted inside of you today? **Yes** _____ **No** _____

13) List each prescription medication you have taken **for more than 3 months at a time, within the last 3 years prior to the implantation of your first Pelvic Mesh Product until the present,** giving the name and address of the pharmacy where you received/filled the medication, the reason you took the medication, and the approximate dates of use.

Medication and Dosage	**Pharmacy (Name and Address)**	**Reason for Taking Medication**	**Approximate Date(s) of use**

IV. INSURANCE INFORMATION

1) Provide the following information, to the best of your knowledge, for any past or present medical insurance coverage within the last 10 years:

Insurance Company (Name and Address)	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

2) Are you receiving Medicare benefits due to age, disability, conditions or any other reason or basis?

Yes_____**No** _____

The date on which you first began receiving such benefits: _____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

3) Has Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last (10) years?

Yes _____**No** _____ If **Yes**, please specify the following:

a) Medicare/Medicaid:_____

b) Address:_____

c) Dates of Service:_____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C.

1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

4) Have you ever been denied life insurance for reasons relating to your health?

Yes _____ **No** _____ If **Yes**, please state when the denial occurred, the name of the life insurance company, and the company's reason for denial: _____

_____

5) Have you personally paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by a Pelvic Mesh Product and for which you seek recovery in the action you have filed?

Yes _____ **No** _____

If **"Yes,"** state the total amount of such expenses at this time (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific):

$_____

6) Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of a Pelvic Mesh Product and for which you seek recovery in the action you have filed?

Yes_____ **No** _____

If **"Yes,"** state the total amount of such expenses at this time (to the extent you were implanted with more than one Pelvic Mesh Product, please be specific):

$_____

V. PRIOR CLAIM INFORMATION

1) Have you filed a lawsuit or made a claim in the last 10 years, other than in the present suit relating to any bodily injury?

Yes _____ **No** _____ If **Yes**, please specify the following:

a) Court in which suit/claim filed or made:_____

b) Case/Claim Number:_____

c) Nature of Claim/Injury:_____

2) Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the past 10 years?

Yes _____ **No** _____ If **Yes**, please specify the following:

a) Date (or year) of application: _____

b) Type of benefits sought _____

c) Agency/Insurer from which you sought the benefits:_____

d) The nature of the claimed injury/disability: _____

e) Whether the claim was accepted or denied: _____

_____

3) Have you ever filed for bankruptcy?

Yes _____**No** _____ If **Yes**, please specify the following:

a) Court in which petition was filed: _____

b) Case/claim number: _____

c) Resolution of case: _____

VI. FACT WITNESSES

1) Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your Healthcare Providers, and please state their name address and his/her/their relationship to you:

Name	Address	Relationship to You

VII. ELECTRONICALLY STORED INFORMATION

For the three years prior to implantation of your first Pelvic Mesh Product(s) to present, please identify any websites that you own, maintain, use for social networking, instant messaging, tweeting, blogging, or otherwise posting messages on-line, including Facebook, Twitter, or Instagram, where you have posted anything with regard to your lawsuit, claims or any of the Pelvic Mesh Product(s), aside from communications with your attorneys, and provide the name or identity used by you in connection with those websites or postings.

_____

_____

_____

VIII. AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Ethicon, Inc. and/or its attorneys or agents to obtain those records identified in the authorizations, and send those executed authorizations immediately to the records-collection provider identified in Ex. A:

IX. DOCUMENTS

State whether you have any of the following documents in your possession, custody, and/or control. If you do, please provide a true and correct copy of any such documents, with this completed Fact Sheet.

a) If you were appointed by a court to represent the plaintiff in this lawsuit, produce any documents demonstrating your appointment as such.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

b) If you represent the estate of a deceased person in this lawsuit, produce a copy of the decedent's death certificate and autopsy report (if applicable).

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

c) Produce any communications in your possession (sent or received) concerning all Pelvic Mesh Product(s), including e-mails, letters, blog entries and newsletters. Social media websites, including but not limited to Facebook, Twitter, or Instagram, are not included within this request and will be addressed later.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

d) Produce all documents or records in your possession relating to the bodily injuries, conditions and/or symptoms identified in your responses to questions II. (3), (3)(a), (10) and (11) of this Fact Sheet.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

e) Produce all documents or records in your possession relating to the surgeries, conditions and/or injuries identified in your responses to questions III. (3), (4) and (6) of this Fact Sheet.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

f) If you are advancing a claim for emotional or psychological injuries, produce all documents or records in your possession which refer or relate to any psychological, psychiatric, counseling, or other mental health treatment that you have received in the last 10 years.

i. Not Applicable

ii. The documents are attached [OR] I have no documents

g) Produce all documents or records in your possession relating to the prescriptions identified in your response to question III. (13) of this Fact Sheet.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

h) Produce documents, including notes, diary or journal entries, and sufficient photographs, DVDs, videos, or other media to show: (1) the conditions which led to the surgery in which you received any Pelvic Mesh Product, or (2) the injuries or conditions for which you claim relief in this lawsuit. This request is limited to the time period beginning three years prior to your surgery until the present.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

i) Produce any Pelvic Mesh Product packaging, labeling, advertising, patient brochures, or any other Pelvic Mesh Product-related items in your possession.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

j) Produce all documents concerning any communication between you and the Food and Drug Administration (FDA) or between you and any employee or agent of the Defendants, regarding all Pelvic Mesh Product(s) at issue.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

k) Produce all documentation in your possession of correspondence or communication between any of the Defendants (or any of their related companies or divisions) and any of your doctors, Healthcare Providers, and/or you relating to the Pelvic Mesh Product(s).

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

l) Produce any and all documentation in your possession of any instructions or warnings you received prior to implantation of any Pelvic Mesh Product(s) concerning the risks and/or benefits of your surgery, including but not limited to any risks and/or benefits associated with any Pelvic Mesh Product(s).

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

m) Produce any and all documents reflecting the product code and lot number of any Pelvic Mesh Product(s) you received.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

n) If you claim lost wages or lost earning capacity, copies of your federal and state tax returns for the 5 years prior to your surgery until the present.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

o) Produce any and all statements by any party or any other person with knowledge relevant to this lawsuit, including their agents, servants, employees, officers or directors, regarding the Plaintiff and her condition, excluding work product.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

p) Produce any and all documents regarding monies expended or expenses incurred for hospitals, doctors, nurses, x-rays, medicines and other health care related to the injuries and/or conditions you allege in this action.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

q) Produce any and all documents which itemize any and all other losses or expenses not otherwise set forth, incurred as a result of your injury and/or condition which forms the basis of this action.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

r) Produce any and all documents which identify money which you have received as a result of your injury and/or condition which forms the basis of this lawsuit.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

s) Produce any and all settlement agreements, releases and forms of payment relating to any other legal proceeding related to your claims and alleged injuries.

i. Not Applicable _____

ii. The documents are attached_____[OR] I have no documents _____

SWORN DECLARATION

Plaintiff,_____, deposes and states as follows:

I certify under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in Section IX of this Fact Sheet to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in Section VIII of this Fact Sheet.

Dated: _____ _____

Signature

EXHIBIT A
to PFS

CMO 66 – AMS DEFENDANT AUTHORIZATIONS

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF
PATHOLOGY MATERIALS PURSUANT TO 45 CFR 164.508

TO: _____
Name of Healthcare Provider/Physician/Facility

_____
Address

_____
City, State and Zip Code

RE: Patient Name:_____

Date of Birth:_____ Social Security Number: _____

Address: _____

_____

I authorize the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian/department of surgery/department of pathology of all covered entities under HIPAA identified above disclose the following: gross and microscopic material or any other of my pelvic floor tissue excised or explanted from me, including but not limited to slides, special stains, blocks, and gross material, from the surgery that took place on/will take place on _____ [date], as requested by representatives of me and defendant American Medical Systems, Inc. This protected health information is disclosed for purposes of my personal injury lawsuit pending in the in The Superior Court of New Jersey and for Bergen County.

You are authorized to release the above pathology materials to the following representatives of myself and defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such materials:

Representative of Patient/Plaintiff(s):	Representative of Defendant AMS:
_____ Name of Representative	Heather A. Ritch Name of Representative
_____ Attorney for Plaintiff(s)	Reed Smith LLP Attorney for Defendant AMS
_____ Street Address	Three Logan Square, 1717 Arch Street Street Address
_____ City, State and Zip Code	Philadelphia, PA 19103 City, State and Zip Code

I acknowledge that I have the right to revoke this authorization, in writing, by sending written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this

authorization cannot be reversed, and my revocation will not affect those actions. I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____

Signature of Patient or Personal Representative

_____

Dated

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority to
Sign for Patient (attach documents which show authority)

_____

Witness Signature

_____

Dated

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To:

I, the undersigned, hereby authorize and request the Custodian above-named entity to disclose to Medical Research Consultants (MRC), 10550 Richmond Avenue, Suite 310, Houston, TX 77042 any and all medical records, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. This authorization specifically does not permit Medical Research Consultants (MRC) to discuss any aspect of medical care or circumstances ex parte and without the presence of my attorney. Records requested may include, but are not limited to:

1. all medical records, physician's records, surgeon's records, pathology/cytology reports, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, prescription records, medication records, orders for medications, pathology/cytology or hematology slides, wet tissue or tissue blocks, therapists' notes, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records, copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports and requisition records, and any other written materials in its possession relating to any and all medical diagnoses, medical examinations, medical and surgical treatments or procedures. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

2. complete copies of all prescription profile records, prescription slips, medication records, orders for medication, payment records, insurance claims forms correspondence and any other records. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. American Medical Systems, Inc, et al. (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

• The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing Medical Research Consultants (MRC) except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).

• The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.

• The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.

• The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDSrecords and information to Medical Research Consultants (MRC).

• The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.

• The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Medical Research Consultants (MRC).

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Medical Research Consultants (MRC).

Name of Patient	Signature of Patient or Individual
Former/Alias/Maiden Name of Patient	Date
Patient's Date of Birth	Name of Patient Representative
Patient's Social Security Number	Description of Authority

Patient's Address

AUTHORIZATION AND CONSENT
TO RELEASE PSYCHOTHERAPY NOTES

Name of Individual:
Social Security Number:
Date of Birth:
Provider Name:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to _____ and its authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ v.

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either _____ _____and to _____ and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and ultimately furnished to _____ in accordance with orders of the court pursuant to this authorization will be shared with any and all

co-defendants in the matter of _____ v.

- and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. or (ii) five (5) years after the date of signature of the undersigned below.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to _____ and its authorized representatives, by any entities included in the categories listed above.

Date: _____ _____

Signature of Individual or Individual's Representative

Individual's Name and Address:

_____ _____

Printed Name of Individual's Representative (If applicable)

_____ _____

Relationship of Representative to Individual (If applicable)

_____ _____

Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

AUTHORIZATION TO DISCLOSE INSURANCE INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to _____, any and all records containing insurance information, including those that may contain protected health information (PHI) regarding _____**,** whether created before or after the date of signature. Records requested may include, but are not limited to:

> applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or any information contained in the materials produced without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v.** or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to the _____, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by _____.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to _____.

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE MEDICAID INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of _____, any and all records containing Medicaid information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of _____ to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

> all Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospitals, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of _____; records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my medical history by _____ without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to _____, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by _____.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to _____.

Name of Individual	Signature of Individual or Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose _____, any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____**,** whether created before or after the date of signature. Records requested may include, but are not limited to:

> all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my employment history by _____ without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v.** or (ii) five (5) years after the date of signature of the undersigned below. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to _____, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by _____.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to _____.

Name of Employee	Signature of Employee or Employee Representative
Former/Alias/Maiden Name of Employee	Date
Employee's Date of Birth	Name of Employee Representative
Employee's Social Security Number	Description of Authority
Employee's Address	

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to _____, any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v.** or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. This authorization is for the release of records only and does not allow for ex parte communications regarding the subject matter of this release and without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to _____, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by _____.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to _____.

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:
Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:	
Address:		
City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:	Release **all** records to date Release records in timeframe from start date _____ to end date: _____
NY residents only:	Include all records Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or Identify a future date or event when the authorization will expire.

Select **one** option:	One-time disclosure Expiration upon specified date _____ Expiration upon specified event _____

SECTION C: RELEASE INFORMATION TO

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name	Recipient 1 Email Address
Recipient 1 Mailing Address:	

SECTION D: PURPOSE FOR REQUEST

This section helps Medicare understand the reason or intent for use for this record request.

At the request of the individual	Litigation

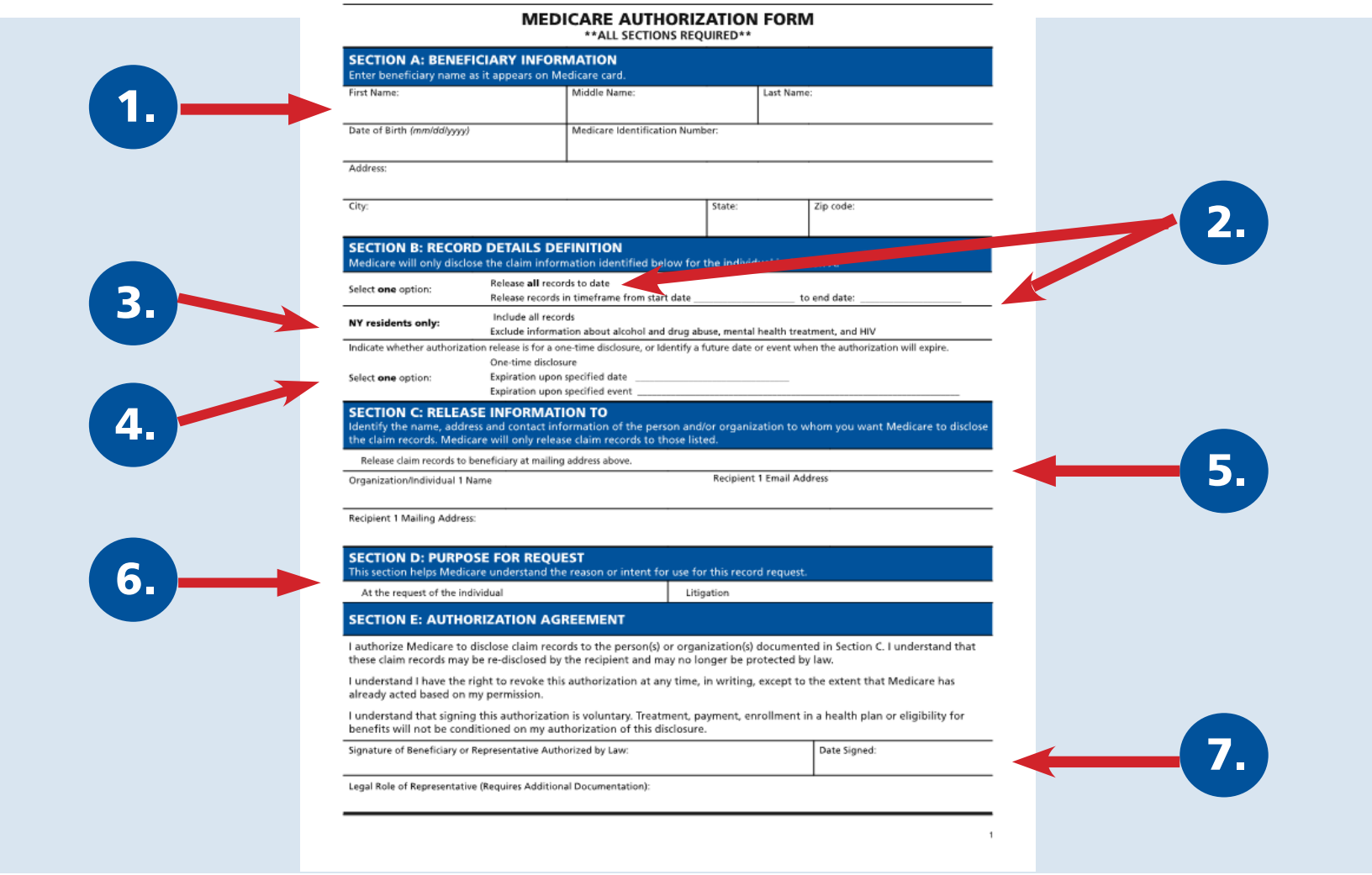
SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law:	Date Signed:
Legal Role of Representative (Requires Additional Documentation):	



1. BENEFICIARY INFORMATION

Add beneficiary name and ID number as printed on Medicare identification card, date of birth, and address.

2. RECORD TIMEFRAME

Indicate date range of records to release, or select "release all records."

3. NY RESIDENTS: EXCLUSIONS OPT-IN

(NY residents only) Specify whether to exclude records related to alcohol and drug abuse, mental health treatment, and HIV.

4. SELECT EXPIRATION DATE OR EVENT

Indicate date or event information release authorization will expire, if you are not requesting a one-time disclosure.

5. SPECIFY ORGANIZATION TO RELEASE TO

Specify individual(s) to whom records should be released. First name, last name, and address are required. Additional contact information provided will be used only to follow up on questions related to your application submission.

6. SELECT REASON FOR REQUEST

Select purpose for record release request to help Medicare understand how records will be used.

7. BENEFICIARY SIGNATURE

Signature and date by beneficiary or authorized representative in acceptance of HIPAA clauses required to release information. If form not signed by beneficiary, attach notarized Power of Attorney (living individual), or Letters Testamentary and/ or Letters of Administration from the court (deceased individual).

TOOL FOR REQUESTING BENEFICIARY RECORDS

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Regional Office:	New York Regional Office
Address:	26 Federal Plaza, 38th Floor, New York, NY 10278
Telephone number:	(212) 616-2229
Fax number:	(443) 380-8855 **Fast and secure method
Areas of Coverage	New Jersey, New York, Puerto Rico & US Virgin Islands

CHECKLIST WHEN REQUESTING RECORDS FOR A BENEFICIARY

WHAT TYPE OF MEDICARE BENEFICIARY CLAIMS ARE YOU REQUESTING?

☐ **NOT ENROLLED IN MEDICARE**

Make certain the beneficiary is enrolled in Medicare. If they do not have a Medicare card they are not enrolled and therefore records are not maintained by CMS.

*CMS **does not** maintain non-Medicare claims records.*

You will need to contact the correct insurer.

If the beneficiary is enrolled, check to verify they were enrolled during the requested period.

MEDICARE ADVANTAGE

These claims are not maintained by CMS and are a type of Medicare health plan offered by a private insurance company; Otherwise known as Medicare Part C. (The beneficiary uses a private insurance card in lieu of their Medicare card when seeking medical care.)

*CMS **does not** maintain Medicare Advantage claims records.*

You will need to submit your request directly to the specific private insurance company. (e.g. HMO, PPO, etc.)

☐ **MEDICAID**

Medicaid is administered by your state or territory agencies and are not maintained by CMS.

*CMS **does not** maintain Medicaid claims records.*

You will need to submit your request directly to the state agency.

State contact information:

New Jersey
http://www.state.nj.us/humanservices/dmahs/ staff/info/

New York
https://www.health.ny.gov/health_care/ medicaid/medicaid_release.htm

Puerto Rico
http://www.medicaid.pr.gov

US. Virgin Islands
http://www.dhs.gov.vi/contact/index.html

TOOL FOR REQUESTING BENEFICIARY RECORDS

ORIGINAL MEDICARE
These records are maintained by CMS; The fee-for-service program in which the government pays for health care costs. The coverage – which includes **Medicare Part A** (inpatient/hospital), **Medicare Part B** (outpatient/medical).

FOR ORIGINAL MEDICARE REQUESTS YOU WILL NEED:

Authorization form

ALL sections completed

☐ Signed and dated by individual whose records are requested

OR

☐ Signed and dated by a personal representative of the individual (This signatory requires Power of Attorney or Letters Testamentary or Letters of Administration. Requests not signed by the individual whose records are requested cannot be processed without these documents)

See attached (enclosed) form.

Request/Cover letter including

Contact Name (first and last name)

Signed Signature (or digital signature)

Detail of the records requested

Proof of authority to represent individual when signed by a personal representative of the individual.

☐ Power of Attorney for living individuals (must be notarized)

☐ Letters Testamentary or Letters of Administration from the court (for deceased individuals)

*MUST accompany request when requestor is **not** the individual whose records are requested.*

FAX request to Regional office at: (443) 380-8855

Fax is most secure and yields quickest response

OTHER TYPES OF REQUESTS

Medical Records

Contact the Beneficiary's providers

Need MSP lien information?
(Subrogation amounts, worker's compensation)

Contact the Benefits Coordination and Recover Center (BCRC) directly:

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html

Need Social Security Administration documents?
(e.g.; premiums, eligibility)

Send your request to:

Social Security Administration
26 Federal Plaza/Room 40-60
New York, NY 10278

Other Questions may be emailed to:

02FOIARF@cms.hhs.gov

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov. **Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

MRC

***ADDRESS OF PERSON OR ORGANIZATION:**

10550 Richmond Ave, Suite 310

Houston, TX 77042

***I want this information released because:** I am involved in civil litigation.

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

CMO 66 – BOSTON SCIENTIFIC DEFENDANT AUTHORIZATIONS

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to The Marker Group, 13105 Northwest Freeway, Suite 300, Houston, TX 77040, any and all medical records, including those that may contain protected health information (PHI) regarding _____ whether created before or after the date of signature. This authorization specifically does not permit The Marker Group to discuss any aspect of medical care or circumstances ex parte and without the presence of my attorney. Records requested may include, but are not limited to:

a. all medical records, physician's records, surgeon's records, pathology/cytology reports, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, prescription records, medication records, orders for medications, therapists' notes, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records, copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports and requisition records, and any other written materials in its possession relating to any and all medical diagnoses, medical examinations, medical and surgical treatments or procedures. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. This authorization and release also allows for the release of pathology/cytology specimens, extracted mesh, pathology/cytology or hematology slides, wet tissue or tissue blocks.

b. complete copies of all prescription profile records, prescription slips, medication records, orders for medication, payment records, insurance claims forms correspondence and any other records. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. _____ or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to The Marker Group except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- The individual signing this authorization understands that the covered entity to whom this authorization Is **directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, In such case, the** disclosed PHI no longer **will be** protected by federal privacy regulations.
- The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to The Marker Group.
- The Individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.
- The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by The Marker Group.

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to The Marker Group .

Name of Individual	Signature of Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION AND CONSENT TO RELEASE PSYCHOTHERAPY NOTES

Name of Individual:
Social Security Number:
Date of Birth:
Provider Name:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers
The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees
The Social Security Administration
Open Records, Administrative Specialist, Department of Workers' Claims
All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to The Marker Group, 13105 Northwest Freeway, Suite 300, Houston, TX 77040 and its authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HlPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. The purpose of this authorization is for civil litigation. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ v. _____.

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either Faegre Drinker and to The Marker Group and / or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and ultimately furnished to The Marker Group in accordance with orders of the court pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ v. _____ and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ _____ v. _____ or (ii) five (5) years after the date of signature of the undersigned below.

I **have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to _____ and its authorized representatives, by any entities included in the categories listed above.**

_____	_____
Name of Individual	Signature of Individual
_____	_____
Former/Alias/Maiden Name of Individual	Date
_____	_____
Individual's Date of Birth	Name of Individual Representative
_____	_____
Individual's Social Security Number	Description of Authority
_____	
_____	
Individual's Address	

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "IDPAA").

AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

TO:

I, the undersigned, hereby authorize and request the above-named entity to disclose to The Marker Group, 13105 Northwest Freeway, Suite 300, Houston, TX 77040, any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____ whether created before or after the date of signature. Records requested may include, but are not limitedto:

- All applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte or oral communication about me or my employment history to The Marker Group without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. _____ or (ii) five (5) years after the date of signature of the undersigned below. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to The Marker Group except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- The individual signing this authorization understands that the covered entity to whom this authorization Is **directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, In such case, the** disclosed PHI no longer **will be** protected by federal privacy regulations.
- The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to The Marker Group.
- The Individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.
- The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by The Marker Group.

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to __ The Marker Group .

Name of Individual	Signature of Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE INSURANCE INFORMATION

TO:

I, the undersigned, hereby authorize and request the above-named entity to disclose to The Marker Group, 13105 Northwest Freeway, Suite 300, Houston, TX 77040, any and all records containing insurance information, including those that may contain protected health information (PHI) regarding _____ whether created before or after the date of signature. Records requested may include, but are not limitedto:

- Applications for insurance coverage and renewals, all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities ender HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or any information contained in the materials produced without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. _____ or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to The Marker Group except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- The individual signing this authorization understands that the covered entity to whom this authorization Is **directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, In such case, the** disclosed PHI no longer **will be** protected by federal privacy regulations.
- The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to The Marker Group.
- The Individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.
- The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by The Marker Group.

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to __ The Marker Group .

Name of Individual	Signature of Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

TO:

I, the undersigned, hereby authorize and request the above-named entity to disclose to The Marker Group, 13105 Northwest Freeway, Suite 300, Houston, TX 77040, any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding _____ _____whether created before or after the date of signature. Records requested may include, but are not limited to:

- All workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claims forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ _____ v. _____ or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. This authorization is for the release of records only and does not allow for ex parte communications regarding the subject matter of this release and without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to The Marker Group except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- The individual signing this authorization understands that the covered entity to whom this authorization Is **directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, In such case, the** disclosed PHI no longer **will be** protected by federal privacy regulations.
- The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to The Marker Group.
- The Individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.
- The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by The Marker Group.

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to __ The Marker Group .

Name of Individual	Signature of Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

Form **4506**

(September 2018)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

_____	_____	_____	_____
_____	_____	_____	_____

8 **Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☒

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☒ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*. Information about any recent developments affecting Form 4506, Form 4506-T and Form 4506T-EZ will be posted on that page.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of nonfiling, and records of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

AUTHORIZATION TO DISCLOSE MEDICAID INFORMATION

TO:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of The Marker Group, 13105 Northwest Freeway, Suite 300, Houston, TX 77040, any and all records containing Medicaid information, including those that may contain protected health information (PHI) regarding _____ whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of The Marker Group to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

- All Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospitals, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of _____; records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. _____ or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. By signing this authorization, I expressly do not authorize any ex parte interview or oral communications about me or my medical history by The Marker Group without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to The Marker Group except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- The individual signing this authorization understands that the covered entity to whom this authorization Is **directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, In such case, the** disclosed PHI no longer **will be** protected by federal privacy regulations.
- The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to The Marker Group.
- The Individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.
- The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by The Marker Group.

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to __ The Marker Group .

Name of Individual	Signature of Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.**

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Instructions for Completing Section 2B of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, in the space provided, write: "all information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, write "Exclude information about alcohol and drug abuse, mental health treatment and HIV" in the space provided. *You may also check any of the remaining boxes and include any additional limitations in the space provided.* For example, you could write "payment information". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Information to Help You Fill Out the
"1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

   Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters (for example, 123456789A).

   Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2b that apply to the type of information you want Medicare to give out.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

5. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

   If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

7. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) _____ **Medicare Number** (Exactly as shown on the Medicare Card) _____ **Date of Birth** (mm/dd/yyyy) _____

2. Medicare will only disclose the personal health information you want disclosed.

   2A: **Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:**

   ☐ Limited Information (go to question 2b)

   ☒ Any Information (go to question 3)

   2B: **Complete <u>only</u> if you selected "limited information". Check all that apply:**

   ☐ Information about your Medicare eligibility

   ☐ Information about your Medicare claims

   ☐ Information about plan enrollment (e.g. drug or MA Plan)

   ☐ Information about premium payments

   ☐ Other Specific Information (please write below; for example, payment information)

   _____

3. **Check only <u>one</u> box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   ☒ Disclose my personal health information indefinitely

   ☐ Disclose my personal health information for a specified period only
   beginning: (mm/dd/yyyy)_____ and ending: (mm/dd/yyyy) _____

4. Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

1. Name: The Marker Group

   Address: 13105 Northwest Freeway, Ste. 300

   Houston, TX 77040

2. Name: Faegre Drinker Biddle Reath, LLP

   Address: 2200 Wells Fargo Center, 90 S. 7th Street

   Minneapolis, MN 55402

3. Name: _____

   Address: _____

   _____

5.

I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

_____ _____ _____

Signature Telephone Number Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

_____

_____

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

_____

_____

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

6. **Send the completed, signed authorization to**:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

7. **Note:**

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**
   Includes periods of employment or self-employment and the names and addresses of employers.

2. **Certified Yearly Totals of Earnings**
   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are free to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, authorizes us to collect the information on this form. We will use the information you provide to identify your records and send the earnings information you request. Completion of this form is voluntary; however, failure to do so may prevent your request from being processed.

We rarely use the information in your earnings record for any purpose other than for determining your entitlement to Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

A complete list of routine uses for earnings information is available in our Systems of Records Notices entitled, the Earnings Recording and Self-Employment Income System (60-0059), the Master Beneficiary Record (60-0090), and the SSA-Initiated Personal Earnings and Benefit Estimate Statement (60-0224). In addition, you may choose to pay for the earnings information you requested with a credit card. 31 C.F.R. Part 206 specifically authorizes us to collect credit card information. The information you provide about your credit card is voluntary. Providing payment information is only necessary if you are making payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order). If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and the Social Security Administration's (SSA) account.

Routine uses applicable to credit card information, include but are not limited to: (1) to enable a third party or an agency to assist Social Security to effect a salary or an administrative offset or to an agent of SSA that is a consumer reporting agency for preparation of a commercial credit report in accordance with 31 U.S.C. §§ 3711, 3717, and 3718; and (2) to a consumer reporting agency or debt collection agent to aid in the collection of outstanding debts to the Federal Government. A complete list of routine uses for credit card information is available in our System of Records Notice entitled, the Financial Transactions of SSA Accounting and Finance Offices (60-0231). The notice, additional information regarding this form, routine uses of information, and our programs and systems is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) One SSN per request

Date of Birth: Date of Death:

Other Name(s) Used
Maiden Name)

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☐ **Itemized Statement of Earnings $91.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Year(s) Requested: to
Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $34.00 fee.

☐ **Certified Yearly Totals of Earnings $34.00**
(Does not include the names and addresses of employers)Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name The Marker Group

Address 13105 Northwest Freeway, Suite 300 State TX

City Houston ZIP Code 77040

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

Signature AND Printed Name of Individual or Legal Guardian | *SSA must receive this form within 120 days from the date signed*
Date

Relationship (if applicable, you must attach proof) | Daytime Phone:

Address | State

City | ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for one ONE Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select **ONE** type of earnings statement and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings
This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings
This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attach the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings
The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings
You can request earnings information from the record of a deceased person if you are:
- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $91.00 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings
In most instances, individuals request Itemized Statements of Earnings for purposes unrelated to our programs such as a private pension plan or personal injury suit. Bulk submitters may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional $34.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings
We charge $34.00 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable. DO NOT SEND CASH.

You may pay by credit card, check or money order.
- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

- **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011	If using private contractor such as FedEx mail form, supporting documentation, and application fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011

- **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$91.00	$125.00

- **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $34.00. You may obtain non-certified yearly totals FREE of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	Area Code
Credit Card Number	
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $34.00, $91.00, or $125.00. SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	Date

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

The Marker Group

***ADDRESS OF PERSON OR ORGANIZATION:**

13105 Northwest Freeway, Suite 300

Houston, TX 77040

***I want this information released because:** Litigation

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. [X] Verification of Social Security Number
2. [X] Current monthly Social Security benefit amount
3. [X] Current monthly Supplemental Security Income payment amount
4. [X] My benefit or payment amounts from date _____ to date _____
5. [X] My Medicare entitlement from date _____ to date _____
6. [X] Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. [ ] Complete medical records from my claims folder(s)
8. [ ] Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

CMO 66 – COLOPLAST DEFENDANT AUTHORIZATIONS

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To:

I, the undersigned, hereby authorize and request the Custodian above-named entity to disclose to Eastwood Legal Nurse Consulting LLC P.O. Box 11482, Bozeman, MT 59719, any and all medical records, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. This authorization specifically does not permit Eastwood Legal Nurse Consulting LLC to discuss any aspect of medical care or circumstances ex parte and without the presence of my attorney. Records requested may include, but are not limited to:

a) all medical records, physician's records, surgeon's records, pathology/cytology reports, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, prescription records, medication records, orders for medications, therapists' notes, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records, copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports and requisition records, and any other written materials in its possession relating to any and all medical diagnoses, medical examinations, medical and surgical treatments or procedures. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. This authorization and release does not allow Eastwood Legal Nurse Consulting LLC to request or take possession of pathology/cytology specimens, extracted mesh, pathology/cytology or hematology slides, wet tissue or tissue blocks.

b) complete copies of all prescription profile records, prescription slips, medication records, orders for medication, payment records, insurance claims forms correspondence and any other records. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v.** Coloplast Corp., et al. or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to** Eastwood Legal Nurse Consulting LLC **except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to** Eastwood Legal Nurse Consulting LLC **.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by** Eastwood Legal Nurse Consulting LLC **.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Eastwood Legal Nurse Consulting LLC .

Name of Patient	Signature of Patient or Individual
Former/Alias/Maiden Name of Patient	Date
Patient's Date of Birth	Name of Patient Representative
Patient's Social Security Number	Description of Authority
Patient's Address	

AUTHORIZATION AND CONSENT
TO RELEASE PSYCHOTHERAPY NOTES

Name of Individual:
Social Security Number:
Date of Birth:
Provider Name:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to Eastwood Legal Nurse Consulting LLC P.O. Box 11482, Bozeman, MT 59719 and its authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ v. Coloplast Corp., et al.

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either King & Spalding LLP 500 W 2nd St, Ste 1800, Austin, TX 78701 and to Eastwood Legal Nurse Consulting LLC and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and ultimately furnished to Eastwood Legal Nurse Consulting LLC in accordance with orders of the court pursuant to this authorization will be shared with any and all

co-defendants in the matter of _____ v. Coloplast Corp., et al.

- and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. Coloplast Corp., et al. or (ii) five (5) years after the date of signature of the undersigned below.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Eastwood Legal Nurse Consulting LLC **and its authorized representatives, by any entities included in the categories listed above.**

Date: _____ _____

Signature of Individual or Individual's Representative

Individual's Name and Address:

_____ _____

Printed Name of Individual's Representative (If applicable)

_____ _____

Relationship of Representative to Individual (If applicable)

_____ _____

Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

AUTHORIZATION TO DISCLOSE INSURANCE INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to Eastwood Legal Nurse Consulting LLC P.O. Box 11482, Bozeman, MT 59719, any and all records containing insurance information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or any information contained in the materials produced without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v.** Coloplast Corp., et al. or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to the** Eastwood Legal Nurse Consulting LLC **, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by** Eastwood Legal Nurse Consulting LLC **.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Eastwood Legal Nurse Consulting LLC

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE MEDICAID INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of Eastwood Legal Nurse Consulting LLC P.O. Box 11482, Bozeman, MT 59719, any and all records containing Medicaid information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of Eastwood Legal Nurse Consulting LLC to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

> all Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospitals, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of _____; records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. Coloplast Corp., et al. or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my medical history by Eastwood Legal Nurse Consulting LLC without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Eastwood Legal Nurse Consulting LLC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Eastwood Legal Nurse Consulting LLC.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Eastwood Legal Nurse Consulting LLC .

Name of Individual	Signature of Individual or Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose Eastwood Legal Nurse Consulting LLC P.O. Box 11482, Bozeman, MT 59719, any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my employment history by Eastwood Legal Nurse Consulting LLC without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v.** Coloplast Corp., et al. or (ii) five (5) years after the date of signature of the undersigned below. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to** Eastwood Legal Nurse Consulting LLC, **except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by** Eastwood Legal Nurse Consulting LLC**.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Eastwood Legal Nurse Consulting LLC_____.

Name of Employee	Signature of Employee or Employee Representative
Former/Alias/Maiden Name of Employee	Date
Employee's Date of Birth	Name of Employee Representative
Employee's Social Security Number	Description of Authority
Employee's Address	

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to Eastwood Legal Nurse Consulting LLC P.O. Box 11482, Bozeman, MT 59719, any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v.** Coloplast Corp., et al. or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. This authorization is for the release of records only and does not allow for ex parte communications regarding the subject matter of this release and without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to** Eastwood Legal Nurse Consulting LLC **, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by** Eastwood Legal Nurse Consulting LLC **.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to __Eastwood Legal Nurse Consulting LLC____.

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

CMO 66 – MENTOR DEFENDANT AUTHORIZATIONS

HIPAA Compliant Authorization to Disclose Health Information

Facility/Provider Name: _____
_____
_____

Facility/Provider Address: _____
_____

I, _____ hereby authorize the above named facility/provider and its staff to disclose certain Medical Information about me to Defendant Mentor Worldwide LLC or its agent(s), including Dustin Rawlin, Esq. of Tucker Ellis, LLP for purposes related to a lawsuit that has been filed by, or on behalf of, me against Mentor Worldwide LLC.

Medical Information, for purposes of this authorization means all information in the above named provider's possession or control pertaining to any medical condition or treatment, including but not limited to: all medical records, physicians records, surgeons records, radiology, x-rays, CAT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films, pathology materials, slides, tissues, physicals and histories, laboratory reports, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, nurses' notes, correspondence, third party correspondence; records of drug abuse and alcohol abuse, AIDS diagnosis or treatment, psychiatric records, psychological records, social workers' records, insurance records, consent for treatment, statements of account, bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning my physical or mental condition.

I understand that Medical Information disclosed to Mentor Worldwide LLC may be redisclosed and may no longer be protected by federal or state privacy laws.

I further understand that I have the ability to revoke with Authorization at any time by providing the above named provider with a written revocation unless the above named provider has already disclosed the Medical Information to Mentor Worldwide LLC or its agent(s) in reliance upon this Authorization. A written revocation should be sent to the address of the above named provider, as written above.

This authorization shall expire one year after it is signed. I further understand that the above named provider will not condition its provision of treatment to me upon my execution of this Authorization and that my participation ins completely voluntary unless any treatment relating to research or healthcare services are provided to me for the purpose of creating protected health information to disclose to a third party. I also understand that I have the ability to inspect or copy Medical Information that will be disclosed to Mentor Worldwide LLC.

_____
Signature of Patient or Personal Representative

_____
Authority for Personal Representative (as applicable)

Dated: _____

EXHIBIT B TO CMO 66

In re PELVIC MESH / GYNECARE LITIGATION,	SUPERIOR COURT OF NEW JERSEY LAW DIVISION, BERGEN COUNTY CIVIL ACTION Case No. 291 CT Master Case 11575-14 Hon. Rachelle L. Harz, J.S.C. DEFENDANT'S DEFENDANT FACT SHEET **Plaintiff[s]:** **Individual Case Docket No.**

For each case, each DEFENDANT must complete this Fact Sheet. Each response must either provide the substantive information requested (and documents, as applicable), or in the event the substantive information requested cannot be provided, the response must provide a detailed explanation as to why the information cannot be provided, including the efforts made to obtain the requested information. This Fact Sheet shall be served in accordance with Case Management Order No. 5 setting forth the procedures for completion and exchange of this document.[1]

I. CASE INFORMATION

This defendant fact sheet pertains to the following case:
Case Name:

II. CONTACTS WITH IMPLANTING AND EXPLANTING[2] PHYSICIANS

A. CONSULTATION AND OTHER NON-SALES REPRESENTATIVE CONTACTS

As to each implanting and explanting physician identified by Plaintiff in response to the PFS who treated and/or evaluated plaintiff for pelvic organ prolapse, stress or urinary incontinence, and/or associated conditions that led to or resulted from the use of the DEFENDANT'S at-issue pelvic mesh product(s) (the "Product(s)"), with whom the

[1] All references to Product(s), the device, surgical device, or implant includes each of DEFENDANT'S female pelvic mesh devices at issue in these matters.

[2] To the extent this DFS refers to an explanting physician, that includes physicians who attempted to explant the mesh, but ultimately could not explant the mesh during the surgery.

DEFENDANT was affiliated, consulted or otherwise had contact outside the context of sales representative contacts, set forth the following information:

1. Identify the physician.

2. Identity and title of each of defendants' employees who had such contact with the physician.

3. Dates of contact/affiliation with physician.

4. Nature of the contact/affiliation with physician.

5. Set forth any monetary and/or non-monetary benefits, including but not limited to money, travel, and drug or device samples, provided to the physician by DEFENDANT or any agent of any named defendant, including amounts, dates, and purpose.

6. For any device manufactured by Defendant, set forth any training provided to or by the physician; including but not limited to date, location, physician's role, cost for attending such training, and subject matter.

7. List any written agreements, contracts, letters, memoranda, or other documents setting forth the nature of the contact with and terms or nature of any contact or affiliation with the physician; this includes but is not

limited to any agreements to research or otherwise study the DEFENDANT'S Product(s).

8. Set forth the number of procedures performed by the physician, to either implant or remove any of DEFENDANT'S Product(s), and the results of those procedures, to the extent known to defendants

9. Set forth any contact between DEFENDANT and the physician with regard to the Plaintiff.

10. Set forth all information provided by the physician to the Defendant with regard to the safety, use, or efficacy of the Product(s).

B. SALES REPRESENTATIVE CONTACTS

As to each sales representative who had any contact with an identified physician who implanted the identified device(s) or who performed any mesh revision or removal procedure on the plaintiff beginning five (5) years prior to and up to the relevant surgery date, set forth the following:

1. Identity of physician.

2. State whether or not the sales representative is currently employed by DEFENDANT. If the sales representative is no longer employed by DEFENDANT, identify the last known address, personal email address, and

telephone number of sales representative if counsel for DEFENDANT confirms it does not represent said former employee

3. The work history and current relationship, if any, between the specified defendant(s) and the sales representative.

4. Identity of the sales representative's supervisor(s) during his/her employment for the response period.

5. The Product(s) that the sales representative marketed, sampled, provided to, or otherwise presented to or discussed with the physician

6. Identify all sales and marketing literature or other information utilized or referenced by the sales representative with regard to the Product(s).

7. Set forth the details of all training and instruction provided to the sales representative with regard to the sale and marketing of the DEFENDANT'S Product(s).

8. Set forth all information provided by the sales representative to the physician with regard to the safety, use, or efficacy of DEFENDANT'S Products.

9. Set forth all information provided by the physician to the sales representative with regard to the safety, use, or efficacy of DEFENDANT'S Product(s).

10. Set forth all information related to the use of the DEFENDANT'S Product(s) provided by the physician to the sales representative, with regard to the plaintiff.

11. Set forth the date, and location of each operation or procedure performed on the plaintiff, which was attended at all by the sales

representative; or whether the sales representative was present at the identified facility on the date of implantation.

12. State whether the sales representative has ever been investigated, reprimanded, and/or otherwise penalized by any person, entity, or government agency for his/her sales or marketing, and if so set forth the details thereof.

III. INFORMATION REGARDING THE PLAINTIFF

A. Identify all data, information, objects, and reports in DEFENDANT'S possession or control or which have been reviewed or analyzed by defendants, with regard to the plaintiff's medical condition; this also includes but is not limited to any study or research that includes plaintiff's specific implant or associated lot number.

B. Identify any direct or indirect contact, either written or oral, between the plaintiff and any employee or representative of DEFENDANT, including but not limited to pre-operative inquiries, and post-operative complaints.

C. Set forth the date, and location of each operation or procedure performed on the plaintiff, which was attended at all by any employee, agent, or contractor of any defendant, and identify the name and position of each person who attended.

D. Identify all Med Watch Adverse Event Reports and/or any other documents submitted to the FDA or any other government agency with regard to the plaintiff.

E. Identify all written information with regard to DEFENDANT'S Product(s) that were used to implant and/or implanted into the plaintiff, which were provided

to the plaintiff and/or her physician, before the implantation of DEFENDANT'S Product(s).

F. Identify all written information with regard to the Defendants' product(s) that were used to implant and/or implanted into the Plaintiff that were available to be provided but were not provided to the Plaintiff and/or her physician.

G. Identify all marketing and advertising information that was publicly available or disseminated with regard to DEFENDANT'S Product(s) that were used

to implant and/or implanted into the plaintiff, on and before the date of implantation.

H. Set forth any information or knowledge defendants have with respect to research studies conducted on or that include information related to plaintiff's implant(s) or associated lot number(s).

I. If you contend that any person, entity, condition, or product, other than the defendants and their product(s), is a cause of the plaintiff's injuries, ("Alternate Cause") set forth:

i) Identify the Alternate Cause with specificity.

ii) Set forth the date and mechanism of alternate causation.

IV. MANUFACTURING INFORMATION

A. Set forth the lot number(s) for DEFENDANT'S Product(s) implanted into the plaintiff, as identified by plaintiff in the PFS.

B. Provide the Device History Record (a.k.a. Batch Record) for the lot. [The Batch Record will address both the finished goods and the component pieces and include a report detailing any nonconformities to the product specifications, if any.]

V. DOCUMENTS

Please ensure that the production of documentation includes specific reference to the question to which the documentation is provided in response. Documentation is

defined to include all forms of documents, including but not limited to paper, email, video, audio, spreadsheets, or otherwise.

A. Identify and attach complete documentation of all information set forth in I through IV above; except, you may identify but not serve copies of medical records that were provided to defendants by plaintiff's counsel.

B. Identify and attach all records, documents, and information that refers or relates to the plaintiff in DEFENDANT'S possession or control, to the extent not identified and attached in response to a prior question.

C. Identify and attach any documents to or from plaintiff's physicians with regard to plaintiff and/or the product(s), to the extent not identified and attached in response to a prior question.

D. Identify and attach any research or patient studies that were conducted using any lot number associated with any product used to implant and/or that was implanted into the plaintiff.

DEFENDANT CERTIFICATION

I hereby certify that I am an agent of DEFENDANT authorized for the purposes of the matters *In Re Pelvic Mesh/ Gynecare Litigation–CT 291,* Bergen County, New Jersey, to certify regarding the accompanying Response of DEFENDANT to the Defendant Fact Sheet that the matters stated therein are not within my personal knowledge, but the facts stated therein have been assembled by authorized employees and counsel for DEFENDANT and I am informed that the facts stated therein are true. I hereby certify, in my authorized capacity as an agent for DEFENDANT, that the responses to the aforementioned Defendant Fact Sheet are true and complete to the best of DEFENDANT'S knowledge.

_____

_____

Print Name, Title