

IN RE ALLEGED ENVIRONMENTAL CONTAMINATION OF POMPTON LAKES	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: BERGEN COUNTY CASE NO. 290 CIVIL ACTION
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ADLH4

CASE MANAGEMENT ORDER NO. ___

FILED

FEB 15 2011

PLAINTIFF FACT SHEET

BRIAN R. MARTINOTTI
J.S.C.

This matter, having been opened to the Court by counsel for the Parties, and the Parties having consented, stipulated and agreed to the entry of this Case Management Order, and good cause appearing therefore;

IT IS, on this 15th day of February 2011, hereby ORDERED as follows:

A. Plaintiff Fact Sheet, Authorizations and Responsive Documents.

1. The parties have agreed upon a Plaintiff Fact Sheet (“PFS”) that includes document requests and a variety of Authorizations. *See* Exhibit 1. Each Plaintiff shall produce to Defendants a completed PFS, executed Authorizations and documents responsive to the document requests (“Responsive Documents”) pursuant to the terms of this Order.

2. A completed PFS, which requires that each Plaintiff sign the declaration on the last page thereof (the “Declaration”), shall be considered to be interrogatory answers and responses to requests for production under the Rules Governing the Court of the State of New Jersey, and will be governed by the standards applicable to written discovery under the Rules Governing the Court of the State of New Jersey. Accordingly, Defendants’ use of the PFS is in lieu of interrogatories and other discovery devices that they would otherwise have propounded, but does not preclude Defendants’ seeking further written discovery requests. As set forth below in Section C, each PFS that is completed must be substantially complete. The PFS questions and requests for production have been negotiated and agreed to by the parties. All objections to the admissibility of information

contained in the PFS are reserved and therefore no objections shall be lodged in the responses to the questions and requests contained in the PFS.

3. Nothing in this section prohibits a Plaintiff from withholding or redacting information based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, Plaintiff shall provide Defendants with a privilege log. In the event that a dispute arises concerning the completeness or adequacy of a Plaintiff's response to any request contained in the PFS, this section shall not prohibit the Plaintiff from asserting that his or her response is adequate.

4. Nothing in the PFS shall be deemed to limit the scope of inquiry at depositions and admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the Rules Governing the Court of the State of New Jersey. The admissibility of information in responses to the PFS shall be governed by the Rules Governing the Court of the State of New Jersey, including all applicable rules of evidence, and no objections are waived by virtue of any PFS response.

B. Schedule of Production of PFSs.

1. Each Plaintiff whose case is docketed in this mass tort proceeding as of the date of entry of this Order and whose name appears on Exhibit 2, Section I, shall produce to Defendants a completed PFS, executed Authorizations and Responsive Documents, in accordance with the schedule attached to this CMO as Exhibit 1.

2. Each Plaintiff whose case is docketed in this mass tort proceeding after the date of entry of this Order shall have 45 days from the date that the first Defendant has served an answer to his or her Complaint to produce to Defendants a completed PFS, executed Authorizations and Responsive Documents.

3. Service of the PFS shall be either in hard-copy or in an electronic format on CD via first class mail, addressed to:

For E.I. DuPont DeNemours and Company, Inc.:
McElroy, Deutsch, Mulvaney & Carpenter, LLP
Three Gateway Center
100 Mulberry Street
Newark, NJ 07102
Attention: Elizabeth A. Kenny, Esq.

For Royle Systems Group, LLC:

Jeffer, Hopkinson & Vogel
1600 Route 208 North
P.O. Box 507
Hawthorne, NJ 07507
Attention: David H. Altman, Esq.

For Valbruna Stainless, Inc.:

Cole, Schotz, Meisel, Forman & Leonard, P.A.
Court Plaza North
25 Main Street, P.O. Box 800
Hackensack, New Jersey 07602-0800
Attention: Glenn R. Kazlow, Esq.

For Alrabwah, Inc.:

[Jeffer, Hopkinson & Vogel
1600 Route 208 North
P.O. Box 507
Hawthorne, NJ 07507
Attention: David H. Altman, Esq.]

C. PFSs Must Be Substantially Complete in All Respects.

Every Plaintiff is required to provide Defendants' Counsel (as set forth above) with a PFS that is substantially complete in all respects. Substantially complete in all respects requires a Plaintiff to:

1. Answer all applicable questions in the PFS (Plaintiff may answer questions in good faith by indicating "not applicable" or "I don't know" or "Unknown");
2. Include a signed Declaration;
3. Provide duly executed record release Authorizations; and

4. Produce the documents requested in the PFS, to the extent such documents are in Plaintiff's possession, custody or control.

D. Authorizations for the Release of Records.

1. As set forth above, Authorizations for the Release of Records together with copies of such records, to the extent that those records or copies thereof are in the Plaintiff's possession, shall be provided, completed in full but for the date, along with the PFS at the time that the Plaintiff is required to serve a PFS pursuant to this Order.

2. In addition to the addressed Authorizations described above, Plaintiffs' counsel shall also maintain in their file unaddressed, executed Authorizations. Plaintiffs' counsel shall provide executed Authorizations to Defendants' counsel within 21 days of a request for Authorizations.

3. Undated Authorizations constitute permission for Defendants to date (and where applicable, re-date) Authorizations before sending to records custodians. Should Plaintiffs provide Authorizations that are undated, this shall not constitute a deficiency or be deemed a substantially non-complete PFS.

4. With respect to Authorizations provided to Defendants that are dated, Defendants and their record copy vendor ("Vendor") are hereby authorized to re-date the Authorizations to the date that they are being sent to the Healthcare Providers and other entities that require Authorizations, provided that the date affixed is not later than December 31, 2012. Defendants and Vendor shall be permitted to "white out" the date and re-date.

5. In the event that a signed Authorization does not contain the following information with respect to the Plaintiff – or, in the case of an Authorization signed in a representative capacity, the information with respect to the represented party – Defendants and Vendor are authorized to fill in the following information:

- a. The name and/or address of the Plaintiff, or represented party, at the top of the Authorization;
- b. The social security number of the Plaintiff or represented party;
- c. The date of birth of the Plaintiff or represented party;
- d. The name of defense counsel or Vendor as the party to whom records may be released.

6. With respect to Authorizations signed “in blank” (i.e., without setting forth the identity of the custodian of records or provider of care), Defendants and Vendor may address such Authorizations and use such Authorizations to obtain records for only those Healthcare Providers and other sources of records identified in the PFS. Defendants or Vendor shall provide e-mail notice to Plaintiff’s counsel when an Authorization is changed consistent with this paragraph three (3) business days prior to sending the Authorization to a provider.

7. In the event that an institution or medical provider to whom any Authorization is presented refuses to provide records in response to that Authorization, Defendants shall notify Plaintiff’s counsel. Should a particular form be required, Defendants will provide it to Plaintiff’s counsel. The individual Plaintiff shall execute and return within 21 days whatever form is required by that institution or provider.

8. Defendants’ Vendor shall have the right to contact institutions or medical providers to follow-up on medical record copying or production.

9. A Plaintiff who is bringing a personal injury claim in this lawsuit shall execute for each of his or her health care providers a copy of the Healthcare Authorization attached as Exhibit A1 to the PFS.

10. Handling Process for Health Care Authorizations for Plaintiffs Who Are Not Bringing A Personal Injury Claim.

- a. With respect to the Healthcare Authorizations for Plaintiffs who are not bringing a personal injury claim in this lawsuit (i.e., Exhibits A2 and A3 to

each PFS), each Plaintiff who is not bringing a personal injury claim in this lawsuit shall execute a copy of Exhibit A2 with respect to each health care provider other than a health care provider who currently provides or in the past has provided services to the Plaintiff that are primarily psychological or psychiatric in nature, or otherwise is focused primarily on patient mental health (such health care provider, a “mental health care provider”).

b. Each Plaintiff who is not asserting a personal injury claim in this lawsuit shall also execute a copy of Exhibit A3 with respect to each mental health care provider, if any.

c. Upon receipt of the documents provided by a mental health care provider pursuant to an Exhibit A3 Authorization, Plaintiffs’ counsel shall have 30 days from receipt of such records to review those documents and to, either: (i) forward all such documents to Defendants counsel; or (ii) forward all such documents to Defendants’ counsel that Plaintiffs’ counsel has determined should be produced and submit any documents that Plaintiffs’ counsel has determined should not be produced to this Court, together with a log of such nonproduced documents (which log will include a description of the reason(s) the documents are not being produced), for consideration of such reasoning. In the event that Plaintiffs’ counsel submits any mental health records of a Plaintiff to this Court, on the same day that such documents are submitted to this Court, Plaintiffs’ counsel shall send a copy of the applicable log to Defendants’ counsel.

E. Non-compliance with PFS Requirements.

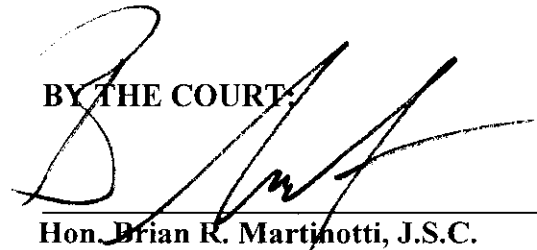
Any Plaintiff (or plaintiff’s representative) who fails to comply with his or her PFS obligations under this Order may be subject to having such plaintiff’s claims, as well as any derivative claim(s), dismissed. If Defendants have not received a completed PFS from a Plaintiff within 20 days following the due date set forth herein, Defendants will send a Notice of Overdue Discovery to Plaintiffs’ counsel identifying the discovery overdue and stating that, unless the

Plaintiff complies with the Court's discovery orders, the case may be subject to dismissal. If Defendants have not received a completed PFS within 21 days after serving a Plaintiff with a 20-day notice, Defendants may move the Court for an Order dismissing the Complaint without prejudice. Plaintiff shall have 14 days from the date of Defendants' motion to file a response either certifying that the Plaintiff has served upon Defendants and Defendants have received a completed PFS, and attaching appropriate documentation of receipt or an opposition to Defendants' motion. If a Plaintiff files such a notice, the Plaintiff's claims shall not be dismissed. Unless Plaintiff has served Defendants with a completed PFS or has moved to vacate the dismissal without prejudice within 60 days after entry of any such Order of Dismissal without Prejudice, the order will be converted to a Dismissal with Prejudice upon Defendants' motion.

F. Copies of Records.

Defendants or their designee(s) shall make available all records obtained by use of Authorizations to the attorney of record for each individual Plaintiff within 30 days of the receipt of the records. The parties shall meet and confer concerning the mechanism for providing copies of medical records and the payment for such copies.

BY THE COURT:



Hon. Brian R. Martinotti, J.S.C.

EXHIBIT 1

PFS Submission Schedule

1. Plaintiffs shall produce 50 PFSs, in accordance with this Order, on or prior to the last day of each calendar month during which there are still Plaintiffs for which a PFS has yet to be submitted; provided, however, that the first 50 PFSs shall be due on the last day of the calendar month following the month in which this order is So Ordered.

2. The order with which the PFSs shall be compiled shall be alphabetical order, alphabetized by the last name of the first Plaintiff listed in the caption of a complaint (it being understood that PFSs for all other Plaintiffs listed in the caption for a complaint that is next in line for PFS production shall be produced as if they alphabetically immediately follow the first named Plaintiff in such caption). Notwithstanding the immediately preceding sentence, PFSs for all Plaintiffs who are bringing a personal injury claim in this lawsuit shall be produced (in alphabetical order themselves) before any PFSs for Plaintiffs who are not bringing a personal injury claim in this lawsuit; and PFSs for the Plaintiffs that are subject to the motion for enforcement brought by DuPont, currently before Judge Dennis Cavanaugh in Federal Court for the District of New Jersey, which Plaintiffs are listed on the attachment to this Exhibit, shall not be compiled in alphabetical order, but instead shall be put "on hold" pending the outcome of the indicated motion. In the event that the decision of Judge Cavanaugh is that some or all of the claims of some or all of those "on hold" Plaintiffs remain viable, PFSs for each Plaintiff with a viable claim shall be produced in accordance with this schedule, but after the production of PFSs for the Plaintiffs who are not subject to the motion to enforce.

3. Nothing in this Schedule shall prohibit Plaintiffs from submitting completed PFSs, in any order, prior to the time they are required to do so pursuant to this Schedule.

Attachment to Exhibit 1

[list of Agnes Plaintiffs]

**IN RE ALLEGED ENVIRONMENTAL
CONTAMINATION OF POMPTON
LAKES**

**SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY**

CASE NO. 290 (CM)

CIVIL ACTION

PLAINTIFF FACT SHEET

Instructions and definitions:

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the questions with respect to the plaintiff for whom you are providing answers. This Fact Sheet is a legal document. You are answering this Fact Sheet under oath and you must answer it truthfully, to the best of your knowledge. After completing this Fact Sheet, sign it on the last page in the presence of a notary public.

Please complete this Fact Sheet clearly and legibly, using a black pen, a typewriter, or a word processor to provide the information.

You must answer this Fact Sheet as completely as possible using all of the information in your possession and control (including if you are answering this Fact Sheet for someone else). If you do not know the answer to a question but you have access to a document that contains or may contain the information, then you must review the document to try to find the information that is being requested. If a question does not apply to you, please answer "Not Applicable".

If the space provided in this Fact Sheet is not enough for you to complete your answer to any question, please continue your answer on the lined sheets at the end of this Fact Sheet or attach as many sheets of paper as necessary to fully answer the questions.

In completing this Fact Sheet, please use the following definitions: (1) "**DuPont**" means E.I. du Pont de Nemours and Company; (2) "**Royle**" means John Royle & Sons, Inc. and/or Royle Systems Group, LLC; (3) "**Valbruna**" means Valbruna Stainless, Inc.; (4) "**DuPont Site**" means the property—sometimes known as the former Pompton Lakes Works—located at 2000 Cannonball Road in Pompton Lakes, New Jersey; (5) "**Royle Site**" means the property located at 1000 Cannonball Road in Pompton Lakes, New Jersey; and (6) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, psychiatric or psychological care or advice, and any pharmacy, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nurse, nutritionist, dietician, or other persons or entities involved in medical or health evaluation, diagnosis, care and/or treatment.

If you have any questions about this Fact Sheet, you should ask your attorneys.

I. CASE INFORMATION

1. The plaintiff's full name is:

First Middle Last

2. Is another person completing this Plaintiff Fact Sheet for the plaintiff?

Yes__ No__

If "Yes", please provide the full name of the person completing this Plaintiff Fact Sheet:

First Middle Last

3. If you answered "Yes" to question 2, please complete the following:

a. Please provide the reason why this Plaintiff Fact Sheet is not being completed by the plaintiff (e.g. if the plaintiff is under the age of 18):

b. That is your relationship to the plaintiff:_____

c. Is the person completing this Plaintiff Fact Sheet also a plaintiff?

Yes__ No__

d. Current Address of the person completing the Plaintiff Fact Sheet and the date when you began living at this address:_____

e. If you were appointed as a representative of the plaintiff by a court, state the:

Court Which Appointed You:_____

Date of Appointment:_____

THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO IS MAKING THE CLAIMS IN THIS CASE. IF YOU ARE COMPLETING THIS FORM FOR SOMEONE ELSE, ASSUME THAT "YOU" IN THE FOLLOWING QUESTIONS REFERS TO THE PERSON FOR WHOM YOU ARE RESPONDING.

II. PERSONAL INFORMATION

4. Plaintiff's date of birth: _____

5. Plaintiff's place of birth: _____

6. Maiden or other names used and the dates you used those names: _____

7. Current address and date when you began living at this address: _____

8. Identify each address at which you have resided since you were born, and the dates you resided at each one.

Address	Dates of Residence

9. Social Security Number: _____

10. Current Marital Status: _____

11. Occupation of current spouse: _____

12. Name(s) of current and former spouse(s), date(s) of marriage(s) and dates the marriage(s) were terminated, if applicable, and the nature of the termination (e.g., death, divorce):

13. If you have children, please identify each child's name, address, date of birth, and (if applicable) date of death.

14. Provide the name and, if known, the address and telephone number of each individual you know likely to have information relevant to the facts you allege in your complaint, identifying the subject matter(s) of the information she or he likely has.

15. Identify all schools you attended, starting with high school:

Name of School	Address and Telephone Number	Dates of attendance	Degree Awarded	Major or Primary Field

16. Are you currently employed? Yes _____ No _____

If "Yes", please identify your current employer and position there: _____

- a. Did you ever leave this job for a medical, physical, or psychiatric reason?
Yes _____ No _____

If "Yes", describe why you left: _____

17. Were you ever employed by DuPont? Yes ___ No ___

If "Yes", please identify the years during which you worked for DuPont, your position(s) at DuPont, and the place(s) of your employment: _____

18. Were you ever employed by Royle? Yes ___ No ___

If "Yes", please identify the years during which you worked for Royle, your position(s) at Royle, and the place(s) of your employment: _____

19. Were you ever employed by Valbruna? Yes ___ No ___

If "Yes", please identify the years during which you worked for Valbruna, your position(s) at Valbruna, and the place(s) of your employment: _____

20. Has any member of your family ever been employed by DuPont, Royle or Valbruna?
Yes ___ No ___

If "Yes", please identify the family member(s), the years during which each family member worked for DuPont, Royle or Valbruna, the position(s) held, and the place(s) of employment: _____

21. Other than the employment you have already identified, please identify every job you have held since high school, the position(s) you held, and the date(s) of employment: _____

22. In any current or former job, have you ever, to the best of your knowledge, worked with, used, or come into contact with volatile organic compounds (e.g. TCE, PCE, cleaning solvents, paint thinners)? Yes _____ No _____

If "Yes", please identify the job, the nature of your contact, and whether your clothes were washed at work: _____

23. In any current or former job, has anyone with whom you live or lived in the past, to the best of your knowledge, worked with, used, or come into contact with volatile organic compounds (e.g. TCE, PCE, cleaning solvents, paint thinners)?

Yes _____ No _____

If "Yes", please identify the job, the nature of the contact, and whether their clothes were washed at work: _____

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

If "Yes", please state the branch of the military and dates of service: _____

If "Yes", were you ever discharged for any reason relating to your medical, physical or psychiatric condition? Yes ___ No ___

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

Have you ever been rejected from military service for any reason relating to your medical, physical, or psychiatric condition? Yes ___ No ___

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

25. Identify each insurance carrier with whom you had health or disability insurance coverage at any time from 1990 to the present, and please include all private insurance and public assistance if applicable:

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

26. Identify each insurance carrier with whom you had life insurance coverage at any time from 1990 to the present:

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

27. Have you ever applied for workers' compensation, social security, or state or federal disability benefits? Yes ___ No ___

If "Yes", then as to each application, separately state:

- a. Date (or year) of application: _____
- b. Type of benefits: _____
- c. Nature of claimed injury/disability: _____

- d. Period of disability: _____
- e. Amount awarded: _____
- f. Basis of your claim: _____
- g. Was your claim denied? Yes _____ No _____
- h. To what agency or company did you submit your application:

- i. Claim/docket number, if applicable: _____

28. Have you ever been denied life insurance for reasons relating to your health?

Yes _____ No _____ I don't know _____

If "Yes", please state when the denial occurred, the name of the life insurance company, and the company's reason for denial:

29. Has an insurance company ever told you that a health-related condition you had or have affected the rate the insurance company would charge you for life insurance?

Yes _____ No _____ I don't know _____

If "Yes", please state when the discussion occurred, the name of the insurance company, and the health-related condition the insurance company identified:

30. Have you ever filed a lawsuit other than the present suit, relating to any injury of any kind (e.g. physical, psychological, psychiatric, emotional, economic, or financial)?

Yes ___ No ___

If "Yes", please explain the nature of the case, where it was filed, and identify the name of your lawyer:

31. Other than this lawsuit and the lawsuit identified in the preceding question, have you ever been a party to a lawsuit, judicial proceeding or made a claim? Yes ___ No ___

If "Yes", please explain the nature of the case, where it was filed, and identify the name of your lawyer:

32. Have you ever been deposed, testified in any administrative proceeding, testified before a grand jury, or testified in court? Yes ___ No ___

If "Yes", please explain the nature of the deposition or testimony, where it occurred, and identify the name of your lawyer:

33. In the last 10 (ten) years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to any crime that involved an alleged act of dishonesty or providing a false statement? Yes ___ No ___

If "Yes", please state the charge to which you pled guilty to or were convicted, as well as the court where the action was pending: _____

34. Does your home have an attached garage directly connected to living space?
Yes _____ No _____

If you answered "Yes", is a car usually parked in the garage?

Yes _____ No _____

If you answered "Yes", are gas-powered equipment or cans of gasoline/fuels stored in the garage?

Yes _____ No _____

35. Do the occupants of your home have their clothes dry cleaned?

Yes _____ No _____

If you answered "Yes", how often? _____

36. Have any pesticides/herbicides been applied around the house or in the yard?

Yes _____ No _____

If you answered "Yes", when, how often, and which chemicals?

37. Has there ever been a fire in the house? Yes _____ No _____

If you answered "Yes", when? _____

38. Have you ever had painting or staining done in the house? Yes ___ No ___

If you answered "Yes", when, and where in the house?

39. Please indicate whether you have or have had in the past in your residence(s)/property(ies) in Pompton Lakes any of the following items, if so where you keep or kept the item (e.g., basement, attached garage, or other room or area), the approximate amount, and approximately how long you have kept or kept the item:

Item	Location(s)	Approx. Amount	Approx. Length of Time
Gasoline storage cans			
Gas-powered equipment			
Kerosene storage cans			
Paints / thinners / strippers			
Cleaning solvents			
Oven cleaners			

Item	Location(s)	Approx. Amount	Approx. Length of Time
Carpet / upholstery cleaners			
Other house cleaning products			
Moth balls			
Polishes / waxes			
Insecticides			
Furniture / floor polish			
Nail polish / polish remover			
Hairspray			
Cologne / perfume			
Air fresheners			
Fuel tank (inside building)			
Wood stove or fireplace			
New furniture / upholstery			
New carpeting / flooring			

40. Do you have or have you had in the past any hobbies in which you use glue, paint and/or cleaning solvents, or any other substance that to your knowledge may include volatile organic compounds? Yes ___ No ___

If "Yes", please identify the hobby, the approximate dates you had or have had the hobby, the chemicals or substances you have used, and where you have worked with those substances:

41. In this action, are you asserting that you should be compensated because of injuries you have sustained from emotional distress based on your fear of developing cancer in the future? Yes ___ No ___
42. Provide a computation of any category of damages you are claiming (breaking down the total amount of damages you are claiming into any categories it may include and providing a computation for each component category).

III. PROPERTY OWNERSHIP (for any plaintiff who is alleging damage to property)

43. For how many properties are you asserting a property claim? _____

If you are asserting a claim for more than one property, answer all of the questions in this section for each property, making clear which property you are referring to in your answers. Use as much additional space as needed to fully answer the questions for each property.

44. What is the address of the property for which you have brought a property claim?

45. Have you ever owned this property? Yes ___ No ___

If you answered "Yes", answer the following questions.

State the date of the purchase: _____

State whether anyone else owned/owns the property with you and, if so, the name(s) of the co-owners:

State the date on which you purchased the property:

State the amount paid for the property: _____

State the name(s) of the person(s) who sold you the property:

State whether you have ever resided at the property and, if so, provide the date(s) during which you resided at the property:

State the name of any realtor, attorney, or other advisor or agent you used or with whom you consulted in connection with the purchase of the property:

State whether you purchased the property using a mortgage or other loan and, if so, identify the name of the lender:

Have you ever sold the property? Yes ___ No ___

If you answered "Yes", provide the following answers.

State the date of the sale: _____

State the sale price: _____

Identify the name of any realtor, attorney, or other advisor or agent you used or with whom you consulted in connection with the sale:

If you answered "No", have you ever tried to sell your property? Yes ___ No ___

If you have tried to sell your property, state the date(s) during which you tried to sell your property, describe your efforts to sell the property (including the period(s) of time the property was for sale and the list price(s)), and identify the name of any realtor, attorney, or other advisor or agent you used or with whom you consulted in connection with the sale:

46. Have you or anyone else ever had your property appraised during the time you have owned your property? Yes ___ No ___

If you answered "Yes", state the date(s) of the appraisal(s), the name of the person(s) who conducted the appraisal(s), the purpose of the appraisal(s) (e.g., sale, refinancing), and the value at which your property was appraised:

IV. SYSTEMS AND TESTING

47. Do you have or have you ever had a vapor or radon mitigation system installed at your residence(s)/property(ies) in Pompton Lakes? Yes ___ No ___

If "Yes", please identify the address(es) of the residence(s)/property(ies) where the system was installed, whether you have or have had a vapor mitigation system, a radon mitigation system, or both, the approximate date of installation(s), and the name(s) of the company that installed the system(s):

If "Yes", have you ever experienced problem(s) with the vapor or radon mitigation system installed at your residence(s)/property(ies)?

Yes _____ No _____

If "Yes", please state the nature of the problem(s), the approximate date(s), what if anything you did to report the problem(s), and whether the problem(s) were resolved:

48. Have you ever had your residence(s)/property(ies) in Pompton Lakes tested for the presence of volatile organic compounds (groundwater, indoor air, slab or otherwise)?
Yes ___ No ___

If "Yes", please identify the address(es) of the residence(s)/property(ies), the kind of test(s) done (e.g. groundwater, slab, indoor air), the name(s) of the company doing the testing, and the results of the test(s):

49. Have you ever had your residence(s)/property(ies) in Pompton Lakes tested for the presence of any other chemicals or substances (other than volatile organic compounds), including radon? Yes ___ No ___

If "Yes", please identify the address of the residence(s)/property(ies), the kind of test(s) done, the chemicals or substances, the name(s) of the company doing the testing, and the results of the test(s):

V. COMMUNICATIONS WITH DEFENDANTS

50. Have you ever communicated with DuPont, O'Brien & Gere, or any other person you believe to be a DuPont contractor concerning potential vapor intrusion?

Yes ___ No ___

If "Yes", please identify the type of communication (verbal, written), the name(s) of the DuPont employee(s) or contractor(s) with whom you communicated, the approximate date(s) of the communication, and the substance of the communication:

51. Have you ever communicated with DuPont, O'Brien & Gere, or any other person you believe to be a DuPont contractor concerning any other matter? Yes ___ No ___

If "Yes", please identify the type of communication (verbal, written), the name(s) of the DuPont employee(s) or contractor(s) with whom you communicated, the approximate date(s) of the communication, and the substance of the communication:

52. Have you ever communicated with Royle concerning potential vapor intrusion? Yes ___ No ___

If "Yes", please identify the type of communication (verbal, written), the name(s) of the Royle employee(s) or contractor(s) with whom you communicated, the approximate date(s) of the communication, and the substance of the communication:

53. Have you ever communicated with Royle concerning any other matter? Yes ___ No ___

If "Yes", please identify the type of communication (verbal, written), the name(s) of the Royle employee(s) or contractor(s) with whom you communicated, the approximate date(s) of the communication, and the substance of the communication:

54. Have you ever communicated with Valbruna concerning potential vapor intrusion?
 Yes ___ No ___

If "Yes", please identify the type of communication (verbal, written), the name(s) of the Valbruna employee(s) or contractor(s) with whom you communicated, the approximate date(s) of the communication, and the substance of the communication:

55. Have you ever communicated with Valbruna concerning any other matter? Yes ___
 No ___

If "Yes", please identify the type of communication (verbal, written), the name(s) of the Valbruna employee(s) or contractor(s) with whom you communicated, the approximate date(s) of the communication, and the substance of the communication:

VI. HEALTH CARE PROVIDERS

56. Identify each doctor or other healthcare provider who you have seen for medical care and treatment:

Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Reason for Visit	Approx. Dates/Years of Visits

57. Identify each hospital, clinic, or health care facility where you were hospitalized (inpatient, out-patient, or emergency room visit):

Name	Address and Telephone Number	Admission Date(s)	Reason for Admission Approx dates/years of visits

VII. MEDICAL BACKGROUND

58. Current Height: _____

59. Current Weight: _____

60. **Tobacco Use History:**

___ I have never used tobacco.

___ I currently use tobacco.

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff) _____

Approximate date tobacco use started: _____

Approximate amount used: _____

___ I do not currently use tobacco, but I used tobacco in the past.

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff) _____

Approximate date tobacco use started: _____

Approximate amount used: _____

Approximate date tobacco use ended: _____

____ If you have used different amounts of tobacco at different times, please identify type(s) of tobacco used, amounts used, and dates of use here:

61. Does anyone with whom you currently live, or did anyone with whom you lived in the past, use tobacco? Yes ___ No ___

If you answered "Yes", please complete the following:

____ I currently live with person(s) who use tobacco.

Name of tobacco user: _____

Relationship to plaintiff: _____

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff) _____

Approximate date tobacco use started: _____

Approximate amount used: _____

Place(s) of use (home, work, car, etc.):

Frequency of use in your presence: _____

____ I do not currently live with anyone who uses tobacco, but I lived in the past with person(s) who used tobacco.

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff) _____

Approximate date tobacco use started: _____

Approximate amount used: _____

Approximate date tobacco use ended: _____

Place(s) of use (home, work, car, etc.):

Frequency of use in your presence: _____

____ If you have lived with person(s) who used different amounts of tobacco at different times, please identify type(s) of tobacco used, amounts used, and dates of use here:

62. Have you ever been tested (e.g. blood or urine testing) for exposure to and/or the presence of any volatile organic compounds, drug, or any environmental or occupational toxin or chemical? Yes ___ No ___

If you answered "Yes", please identify the kind of test(s) that were done, who performed the tests, the date(s) of the tests, and the result(s) of the test(s):

63. Do you currently have or have you ever had a history of any chronic disease or medical condition requiring ongoing medical care? Yes ___ No ___

If you answered "Yes", please identify each such medical condition, the approximate date of onset, the year(s) of treatment (if any), the type of treatment (including prescription medications you regularly take/took to treat the condition), and the name, address, and telephone number of the health care provider and/or health care facility where you were treated:

VIII. FAMILY MEDICAL HISTORY

64. Do you have any siblings? Yes ___ No ___

If “Yes”, please identify each sibling, your relation to that sibling (e.g. brother, half-brother):

65. If any of your siblings are deceased, please identify which sibling(s), the year(s) in which your sibling(s) died, and, to the best of your knowledge, the cause(s) of death:

66. Are your parents living? Yes ___ No ___

If “Yes”, please indicate, to the best of your knowledge, what major disease(s) and medical condition(s) your parents have had:

If “No”, please indicate, to the best of your knowledge, the year(s) in which your parent(s) died, and, to the best of your knowledge, the cause(s) of death:

67. Are your grandparents living? Yes ___ No ___

If “Yes”, please indicate, to the best of your knowledge, what major disease(s) and medical condition(s) your grandparents have had:

If "No", please indicate, to the best of your knowledge, the year(s) in which your grandparent(s) died, and, to the best of your knowledge, the cause(s) of death:

68. If you have (or had) children, please indicate what major disease(s) and medical condition(s) each child has/had, including the date of onset:

IX. MEDICAL MONITORING

69. Has any health care provider ever told you that you should undergo medical monitoring because of exposure to any chemical or substance?

Yes _____ No _____

If "Yes", please identify the name(s) of the health care provider, the date when this advice was given, and describe the nature of the medical monitoring that was recommended to you:

70. Are you currently participating in any medical monitoring program?

Yes _____ No _____

If "Yes", please identify the medical monitoring program, the reason it was instituted, the dates of your participation, the type and frequency of tests that are available, the dates of and type of tests that you received, and the results of any such tests:

X. DOCUMENT REQUESTS

“**Document**” means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, notes, diaries, calendars, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

A. AUTHORIZATIONS

1. Healthcare Authorizations -

- a. If you are bringing a personal injury claim in this lawsuit, for each health care provider identified in this Plaintiff Fact Sheet, please provide a completed and signed (but undated) Healthcare Authorization in the form attached as **Exhibit “A1.”**
- b. If you are **not** bringing a personal injury claim in this lawsuit:
 - (i) For each health care provider identified in this Plaintiff Fact Sheet who currently provides or in the past has provided services to you (or to the Plaintiff for whom you are answering this Plaintiff Fact Sheet) that are **not** primarily psychological or psychiatric in nature, or otherwise focused primarily on patient mental health (such health care providers, “mental health care providers”), please provide a completed and signed (but undated) Healthcare Authorization in the form attached as **Exhibit “A2”; and**
 - (ii) For each mental health care provider identified in this Plaintiff Fact Sheet, please provide a completed and signed (but undated) Healthcare Authorization in the form attached as **Exhibit “A3.”**

2. Authorization for Release of Workers’ Compensation Records – If you are bringing a personal injury claim in this lawsuit and you have applied for workers’ compensation, please provide a completed and signed (but undated) Authorization for Release of Workers’ Compensation Records for each agency or company you submitted your application to in the form attached as **Exhibit “B.”**

3. Authorization for Release of Disability Records - If you have applied for disability, please provide a completed and signed (but undated) Authorization for Release for each agency or company you submitted your application to in the form attached as **Exhibit “C.”**

4. **Insurance Records Authorization**- If you are bringing a personal injury claim in this lawsuit or are asserting injury due to emotional distress based on fear of developing cancer in the future, for each insurance company listed in this Plaintiff Fact Sheet, please provide a completed and signed (but undated) Authorization for Release of Insurance Records in the form attached as **Exhibit "D"**.

B. OTHER RELEVANT DOCUMENTS

Documents in your possession, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession, please indicate which documents you have and attach a copy of them to this Plaintiff Fact Sheet):

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet, including property or medical records of any kind, any notes you took, and any letters you sent or received (but not including telephone books and other generally available sources of information).
Yes _____ No _____
2. A copy of all medical records and/or documents from any hospital or healthcare provider who has treated you for any disease, condition or symptom referred to in any of your responses to the questions above, including any document concerning any medical condition or diagnosis. Yes _____ No _____
3. If you have been the claimant or subject of any workers' compensation, social security or other disability proceeding, all documents relating to such proceeding.
Yes _____ No _____
4. All documents in your possession which mention, refer or relate to DuPont or any DuPont contractor. Yes _____ No _____
5. All documents in your possession which mention John Royle & Sons, Inc. or Royle Systems Group, LLC. Yes _____ No _____
6. All documents in your possession which mention Valbruna Stainless, Inc.
Yes _____ No _____
7. All documents in your possession that refer or relate to vapor intrusion or potential vapor intrusion. Yes _____ No _____
8. All documents in your possession obtained from DuPont, Royle, Valbruna or Alrabwah, Inc. Yes _____ No _____
9. All documents constituting any communications or correspondence between you and any representative of DuPont, Royle, Valbruna or Alrabwah, Inc. (including any letters, notes, diaries, documents, audio or video recordings. Yes _____
No _____

10. All documents that refer or relate to the DuPont Site or the Royle Site.
Yes _____ No _____
11. All documents that refer or relate to vapor mitigation systems, including any vapor mitigation system at your property and vapor mitigation systems generally.
Yes _____ No _____
12. All documents that refer or relate to radon mitigation systems, including any radon mitigation system at your property and radon mitigation systems generally.
Yes _____ No _____
13. All documents constituting any communications or correspondence between you and any representative of DuPont or a person or company other than DuPont relating to the planning, design, installation, or maintenance of a vapor mitigation system or radon mitigation system at your property (including any letters, notes, diaries, documents, audio or video recordings). Yes _____ No _____
14. All documents that refer or relate to any testing for potential vapor intrusion done at your property at any time. Yes _____ No _____
15. If you have a property claim, all documents that refer or relate to any purchase, sale (or attempted sale) of your property, including all purchase and sale or other closing documents and documents pertaining to listing (or potential listing), offers to or from you concerning the property, inspection, property disclosures, and correspondence to or from you, your realtor, lender or other advisor (other than your own attorney), prior or subsequent owners of the property or their respective agents, attorneys, lenders or advisors, and any other document pertaining to the sale (or potential sale) of the property. Yes _____ No _____
16. If you have a property claim, all documents that refer or relate to any appraisal of your property. Yes _____ No _____
17. All documents that refer or relate to any testing you have had (e.g. blood or urine) for exposure to and/or the presence of any volatile organic compounds, drug, or any environmental or occupational toxin or chemical. Yes _____ No _____
18. All releases or settlement agreements you have signed in connection with claims against DuPont or anyone else in connection with the DuPont Site at any time.
Yes _____ No _____
19. Documents or communications that relate to the subject matter of any lawsuit (other than the current lawsuit) in which you were a plaintiff (other than communications to or from your lawyer), that involves or involved any claim relating to alleged contamination or exposure to any pharmaceutical, environmental or occupational toxin or chemical. Yes _____ No _____

20. All documents that relate to your computation of any category of damages you claim in this lawsuit, including materials bearing on the nature and extent of injuries you claim. Yes _____ No _____
21. Communications that relate to the subject matter of this lawsuit (other than communications to or from your lawyer) that are not already referred to in the prior document requests. Yes _____ No _____
22. **SUPPLEMENTAL RESPONSES**

Question _____

Question _____

Question _____

Question _____

Question _____

Question _____

Question _____

23. **DECLARATION**

I hereby certify that the foregoing answers provided in this Plaintiff's Fact Sheet are true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry (including a review of all relevant documents in my possession or control). I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

I hereby certify that I have reviewed the document production requests in Section X(B) of this Plaintiff's Fact Sheet and that I have made or caused to be made a good faith search for documents in my possession responsive to those requests. I further certify that as of this date, to the best of my knowledge and information, the production is complete and accurate. I acknowledge my continuing obligation to make a good faith effort to identify additional documents that are responsive to the request and to promptly serve a supplemental written response and production of such documents, as appropriate, as I become aware of them.

Date: _____

Signature

**AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS / HEALTH INFORMATION (A1)**

HIPAA Compliant/Pursuant to 45 CFR §164.508

INSURED/CLAIMANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip Code Soc. Security No.

I hereby authorize: _____
Name of Provider/Hospital/Clinic disclosing information

Address

its Director or designees, or Medical Information Services Department to release complete copies of all information, records, and reports, including summaries, digests, charts, correspondence, statements, questionnaires, and notes (whether handwritten, typed, or dictated), in your possession, custody, or control relating to my examination, consultation, confinement or treatment (including outpatient treatment and therapy sessions), for any physical, emotional or mental condition or illness, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological services records and social work records, if any, to the individuals or organizations listed below, only under the conditions listed below and in compliance with 45 C.F.R. §164.508(c)(1)(iv). This authorization does not extend to psychotherapy notes, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. §164.501, to mean notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during private, joint or group counseling sessions, and which are kept separate from my medical records.

REQUESTOR/RECIPIENT INFORMATION

1. Person(s) or organization(s) to whom disclosure is to be made:

Elizabeth A. Kenny, Esq., c/o McElroy, Deutsch, Mulvaney & Carpenter, LLP, Three Gateway Center, 100 Mulberry Street, Newark, New Jersey 07102-4079,

David H. Altman, Esq., c/o Jeffer, Hopkinson & Vogel, 1600 Route 208 North, P.O. Box 507, Hawthorne, New Jersey 07507,

Glenn R. Kazlow, Esq., c/o Cole, Schotz, Meisel, Forman & Leonard, P.A., Court Plaza North, 25 Main Street, P.O. Box 800, Hackensack, New Jersey 07602-0800,

Bernard A. Weintraub, Esq., c/o Weitz & Luxenberg, P.C., 700 Broadway, New York, New York 10003,

or the authorized representatives of such attorneys.

2. Specific type of information to be disclosed (information designated above, including but not limited to the following):

<input checked="" type="checkbox"/>	Admission/Discharge Summary	<input checked="" type="checkbox"/>	Operative Reports & Pathology
<input checked="" type="checkbox"/>	Ambulatory Report	<input checked="" type="checkbox"/>	Physical Therapy
<input checked="" type="checkbox"/>	History and Physical Exam	<input checked="" type="checkbox"/>	Consultation Reports
<input checked="" type="checkbox"/>	X-ray Reports	<input checked="" type="checkbox"/>	Laboratory Tests
<input checked="" type="checkbox"/>	Nurse Notes	<input checked="" type="checkbox"/>	Diagnostic Reports

- | | | | |
|-------------------------------------|--|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Progress Notes | <input checked="" type="checkbox"/> | Emergency Room Records |
| <input checked="" type="checkbox"/> | Scans/videos/CDs/films/reels | <input checked="" type="checkbox"/> | Billing Records Including Insurance Records |
| <input checked="" type="checkbox"/> | Pharmacy/prescription records | <input checked="" type="checkbox"/> | Records Received from Other Health Care Providers |
| <input checked="" type="checkbox"/> | Medical Records, including any medical charts or data from the HIS system. | | |

This authorization is limited to the following dates of treatment:

FROM: Initial Consultation TO: Completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

3. Purpose or need for disclosure: To provide copies of documents for evaluation of legal claims by defendants in litigation. This authorization does not permit you, without the patient's consent, to discuss any aspect of those documents with the listed attorneys or their representatives, except as may be required as part of litigation.

4. This authorization expires: Upon completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipients are prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I acknowledge that the information disclosed pursuant to this authorization may be further disclosed by the recipients and may no longer be protected under the HIPAA privacy rules. I understand that you may not condition treatment, payment, enrollment or eligibility benefits based upon whether or not I sign this authorization, unless a condition set forth at 45 C.F.R. §164.508(b)(4) applies.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I also understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to your Health Information Management Department. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization.

Any copy including faxed copies of this Authorization shall have the same force and effect as an original Authorization.

SIGNATURE: _____
Patient

DATE: _____

If legal representative, sign below and state relationship and authority to do so.

SIGNATURE: _____
Legal Representative

DATE: _____

Relationship to Patient

(Description of Representative's Authority)

**AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS / HEALTH INFORMATION HELD BY HEALTH CARE
PROVIDERS OTHER THAN MENTAL HEALTH CARE PROVIDERS (A2)**

HIPAA Compliant/Pursuant to 45 CFR §164.508

INSURED/CLAIMANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip Code Soc. Security No.

I hereby authorize: _____
Name of Provider/Hospital/Clinic disclosing information

Address

its Director or designees, or Medical Information Services Department to release complete copies of all information, records, and reports, including summaries, digests, charts, correspondence, statements, questionnaires, and notes (whether handwritten, typed, or dictated), in your possession, custody, or control relating to my examination, consultation, confinement or treatment (including outpatient treatment and therapy sessions), for any physical condition or illness, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, to the individuals or organizations listed below, only under the conditions listed below and in compliance with 45 C.F.R. §164.508(c)(1)(iv). This authorization does not extend to psychotherapy notes, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. §164.501, to mean notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during private, joint or group counseling sessions, and which are kept separate from my medical records.

REQUESTOR/RECIPIENT INFORMATION

1. Person(s) or organization(s) to whom disclosure is to be made: Elizabeth A. Kenny, Esq., c/o McElroy, Deutsch, Mulvaney & Carpenter, LLP, Three Gateway Center, 100 Mulberry Street, Newark, New Jersey 07102-4079,

David H. Altman, Esq., c/o Jeffer, Hopkinson & Vogel, 1600 Route 208 North, P.O. Box 507, Hawthorne, New Jersey 07507,

Glenn R. Kazlow, Esq., c/o Cole, Schotz, Meisel, Forman & Leonard, P.A., Court Plaza North, 25 Main Street, P.O. Box 800, Hackensack, New Jersey 07602-0800,

Bernard A. Weintraub, Esq., c/o Weitz & Luxenberg, P.C., 700 Broadway, New York, New York 10003,

or the authorized representatives of such attorneys.

2. Specific type of information to be disclosed (information designated above, including but not limited to the following):

- | | |
|---|---|
| <input checked="" type="checkbox"/> Admission/Discharge Summary | <input checked="" type="checkbox"/> Operative Reports & Pathology |
| <input checked="" type="checkbox"/> Ambulatory Report | <input checked="" type="checkbox"/> Physical Therapy |
| <input checked="" type="checkbox"/> History and Physical Exam | <input checked="" type="checkbox"/> Consultation Reports |
| <input checked="" type="checkbox"/> X-ray Reports | <input checked="" type="checkbox"/> Laboratory Tests |
| <input checked="" type="checkbox"/> Nurse Notes | <input checked="" type="checkbox"/> Diagnostic Reports |

- | | | | |
|-------------------------------------|--|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Progress Notes | <input checked="" type="checkbox"/> | Emergency Room Records |
| <input checked="" type="checkbox"/> | Scans/videos/CDs/films/reels | <input checked="" type="checkbox"/> | Billing Records Including Insurance Records |
| <input checked="" type="checkbox"/> | Pharmacy/prescription records | <input checked="" type="checkbox"/> | Records Received from Other Health Care Providers |
| <input checked="" type="checkbox"/> | Medical Records, including any medical charts or data from the HIS system. | | |

This authorization is limited to the following dates of treatment:

FROM: Initial Consultation TO: Completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

3. Purpose or need for disclosure: To provide copies of documents for evaluation of legal claims by defendants in litigation. This authorization does not permit you, without the patient's consent, to discuss any aspect of those documents with the listed attorneys or their representatives, except as may be required as part of litigation.

4. This authorization expires: Upon completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipients are prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I acknowledge that the information disclosed pursuant to this authorization may be further disclosed by the recipients and may no longer be protected under the HIPAA privacy rules. I understand that you may not condition treatment, payment, enrollment or eligibility benefits based upon whether or not I sign this authorization, unless a condition set forth at 45 C.F.R. §164.508(b)(4) applies.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I also understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to your Health Information Management Department. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization.

Any copy including faxed copies of this Authorization shall have the same force and effect as an original Authorization.

SIGNATURE: _____ DATE: _____
 Patient

If legal representative, sign below and state relationship and authority to do so.

SIGNATURE: _____ DATE: _____
 Legal Representative

 Relationship to Patient

 (Description of Representative's Authority)

**AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS / HEALTH INFORMATION
HELD BY MENTAL HEALTH CARE PROVIDERS (A3)**
HIPAA Compliant/Pursuant to 45 CFR §164.508

INSURED/CLAIMANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip Code Soc. Security No.

I hereby authorize: _____
Name of Provider/Hospital/Clinic disclosing information

Address

its Director or designees, or Medical Information Services Department to release complete copies of all information, records, and reports, including summaries, digests, charts, correspondence, statements, questionnaires, and notes (whether handwritten, typed, or dictated), in your possession, custody, or control relating to my examination, consultation, confinement or treatment (including outpatient treatment and therapy sessions), for any physical, emotional or mental condition, or related physical illnesses, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological services records and social work records, if any, to the individuals or organizations listed below, only under the conditions listed below and in compliance with 45 C.F.R. §164.508(c)(1)(iv). This authorization does not extend to psychotherapy notes, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. §164.501, to mean notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during private, joint or group counseling sessions, and which are kept separate from my medical records.

REQUESTOR/RECIPIENT INFORMATION

1. Person(s) or organization(s) to whom disclosure is to be made: Bernard A. Weintraub, Esq., c/o Weitz & Luxenberg, P.C., 700 Broadway, New York, New York 10003, or his authorized representatives.

2. Specific type of information to be disclosed (information designated above, including but not limited to the following):

- | | | | |
|-------------------------------------|--|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Admission/Discharge Summary | <input checked="" type="checkbox"/> | Operative Reports & Pathology |
| <input checked="" type="checkbox"/> | Ambulatory Report | <input checked="" type="checkbox"/> | Physical Therapy |
| <input checked="" type="checkbox"/> | History and Physical Exam | <input checked="" type="checkbox"/> | Consultation Reports |
| <input checked="" type="checkbox"/> | X-ray Reports | <input checked="" type="checkbox"/> | Laboratory Tests |
| <input checked="" type="checkbox"/> | Nurse Notes | <input checked="" type="checkbox"/> | Diagnostic Reports |
| <input checked="" type="checkbox"/> | Progress Notes | <input checked="" type="checkbox"/> | Emergency Room Records |
| <input checked="" type="checkbox"/> | Scans/videos/CDs/films/reels | <input checked="" type="checkbox"/> | Billing Records Including Insurance Records |
| <input checked="" type="checkbox"/> | Pharmacy/prescription records | <input checked="" type="checkbox"/> | Records Received from Other Health Care Providers |
| <input checked="" type="checkbox"/> | Medical Records, including any medical charts or data from the HIS system. | | |

his authorization is limited to the following dates of treatment:

FROM: Initial Consultation TO: Completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

3. Purpose or need for disclosure: To provide copies of documents for evaluation of legal claims by defendants in litigation.

4. This authorization expires: Upon completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I acknowledge that the information disclosed pursuant to this authorization may be further disclosed by the recipients and may no longer be protected under the HIPAA privacy rules. I understand that you may not condition treatment, payment, enrollment or eligibility benefits based upon whether or not I sign this authorization, unless a condition set forth at 45 C.F.R. §164.508(b)(4) applies.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I also understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to your Health Information Management Department. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization.

Any copy including faxed copies of this Authorization shall have the same force and effect as an original Authorization.

SIGNATURE: _____ DATE: _____
Patient

If legal representative, sign below and state relationship and authority to do so.

SIGNATURE: _____ DATE: _____
Legal Representative

Relationship to Patient

(Description of Representative's Authority)

AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

TO:

Name of Insurance Company/Agency

Address of Insurance Company/Agency

RE:

INSURED/CLAIMANT'S NAME _____

DATE OF BIRTH _____

ADDRESS _____

Street

City

State

Zip Code

Soc. Security No.

CLAIM PETITION/
POLICY NO. _____

I hereby request and authorize you to release to the following attorneys, who have agreed to pay reasonable expenses incurred by you to supply such records:

Elizabeth A. Kenny, Esq., c/o McElroy, Deutsch, Mulvaney & Carpenter, LLP, Three Gateway Center, 100 Mulberry Street, Newark, New Jersey 07102-4079,

David H. Altman, Esq., c/o Jeffer, Hopkinson & Vogel, 1600 Route 208 North, P.O. Box 507, Hawthorne, New Jersey 07507,

Glenn R. Kazlow, Esq., c/o Cole, Schotz, Meisel, Forman & Leonard, P.A., Court Plaza North, 25 Main Street, P.O. Box 800, Hackensack, New Jersey 07602-0800,

Bernard A. Weintraub, Esq., c/o Weitz & Luxenberg, P.C., 700 Broadway, New York, New York 10003,

or the authorized representatives of such attorneys, all information, records, claims files and correspondence relating to any and all workers' compensation benefits applied for by me. The sole purpose of the release of this information is to provide copies of those documents for evaluation of my legal claims by defendants in litigation.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipients are prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose state above. I acknowledge that the information disclosed pursuant to this authorization may be further disclosed by the recipients and may no longer be protected under the HIPAA privacy rules. I understand that you may not condition treatment, payment, enrollment or eligibility benefits based upon whether or not I sign this authorization, unless a condition set forth at 45 C.F.R. §164.508(b)(4) applies.

I also understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to your Information Management Department. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization. This

authorization expires upon completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

Any copy including faxed copies of this Authorization shall have the same force and effect as an original Authorization.

SIGNATURE: _____ DATE: _____
Claimant/Petitioner

If legal representative, sign below and state relationship and authority to do so.

SIGNATURE: _____ DATE: _____
Legal Representative

Relationship to Claimant/Petitioner

(Description of Representative's Authority)

**AUTHORIZATION FOR RELEASE OF
DISABILITY BENEFITS INFORMATION**

TO:

Name of Insurance Company/Agency

Address of Insurance Company/Agency

RE:

INSURED/CLAIMANT'S NAME _____ DATE OF BIRTH _____

ADDRESS

_____, _____, _____, _____, _____
Street City State Zip Code Soc. Security No.

POLICY NO. _____

I hereby request and authorize you to release to the following attorneys, who have agreed to pay reasonable expenses incurred by you to supply such records:

Elizabeth A. Kenny, Esq., c/o McElroy, Deutsch, Mulvaney & Carpenter, LLP, Three Gateway Center, 100 Mulberry Street, Newark, New Jersey 07102-4079,

David H. Altman, Esq., c/o Jeffer, Hopkinson & Vogel, 1600 Route 208 North, P.O. Box 507, Hawthorne, New Jersey 07507,

Glenn R. Kazlow, Esq., c/o Cole, Schotz, Meisel, Forman & Leonard, P.A., Court Plaza North, 25 Main Street, P.O. Box 800, Hackensack, New Jersey 07602-0800,

Bernard A. Weintraub, Esq., c/o Weitz & Luxenberg, P.C., 700 Broadway, New York, New York 10003,

or the authorized representatives of such attorneys, all information, records, applications for insurance, policies, underwriting files, claims files and correspondence relating to any and all insurance/disability benefits applied for by me. The sole purpose of the release of this information is to provide copies of those documents for evaluation of my legal claims by defendants in litigation.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipients are prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I acknowledge that the information disclosed pursuant to this authorization may be further disclosed by the recipients and may no longer be protected under the HIPAA privacy rules. I understand that you may not condition treatment, payment, enrollment or eligibility benefits based upon whether or not I sign this authorization, unless a condition set forth at 45 C.F.R. §164.508(b)(4) applies.

I also understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to your Information Management Department. I understand that this

revocation will not apply to the extent that you have already taken action in reliance on this authorization. This authorization expires upon completion of the litigation entitled In re Alleged Environmental Contamination of Pompton Lakes, Case No. 290, pending in the Superior Court of New Jersey, Law Division, Bergen County.

Any copy including faxed copies of this Authorization shall have the same force and effect as an original Authorization.

SIGNATURE: _____
Insured/Claimant

DATE: _____

If legal representative, sign below and state relationship and authority to do so.

SIGNATURE: _____
Legal Representative

DATE: _____

Relationship to Insured/Claimant

(Description of Representative's Authority)

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

TO:

Name of Insurance Company/Agency

Address of Insurance Company/Agency

RE:

INSURED/CLAIMANT'S NAME _____

DATE OF BIRTH _____

ADDRESS _____

Street

City

State

Zip Code

Soc. Security No.

POLICY NO. _____

I hereby request and authorize you to release to the following attorneys, who have agreed to pay reasonable expenses incurred by you to supply such records:

Elizabeth A. Kenny, Esq., c/o McElroy, Deutsch, Mulvaney & Carpenter, LLP, Three Gateway Center, 100 Mulberry Street, Newark, New Jersey 07102-4079,

David H. Altman, Esq., c/o Jeffer, Hopkinson & Vogel, 1600 Route 208 North, P.O. Box 507, Hawthorne, New Jersey 07507,

Glenn R. Kazlow, Esq., c/o Cole, Schotz, Meisel, Forman & Leonard, P.A., Court Plaza North, 25 Main Street, P.O. Box 800, Hackensack, New Jersey 07602-0800,

Bernard A. Weintraub, Esq., c/o Weitz & Luxenberg, P.C., 700 Broadway, New York, New York 10003,

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SIGNATURE: _____ DATE: _____
Insured

If legal representative, sign below and state relationship and authority to do so.

SIGNATURE: _____ DATE: _____
Legal Representative

Relationship to Insured

(Description of Representative's Authority)