Attorneys for Defendants
Johnson & Johnson & Ethicon, Inc.

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER CASE NO. ATL-L-794-19

CASE NO. 630

IN RE PROCEED MESH LITIGATION
(Proceed® Surgical Mesh and Proceed® Ventral Patch Hernia Mesh)

Civil Action

(Third Revised) CASE MANAGEMENT ORDER No. 6

[PLAINTIFF PROFILE FORM]
(Supersedes CMO 6 entered on 9/11/2019, updated 11/13/2019, and updated again on 12/6/2019)

This matter having been opened to The Court by the parties; and the purpose of the amendment of this Order is to update, substitute, and attach the most current versions of authorization for the release of Medicare Records accepted by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, and by the Internal Revenue Service ("IRS"), and to clarify the scope of the obligation to produce certain authorizations, and the parties having indicated they have no objection to the form and entry of the within Order; and good cause appearing;

IT IS on this 27th day of August, 2020,

ORDERED:

The Plaintiff Profile Form and authorizations attached hereto as Exhibit A are hereby adopted for use in this litigation.

a. This Order shall govern: (1) all cases transferred to this Court, including those cases subsequently transferred; and (2) all cases directly filed in this MCL.

b. For any case filed or transferred prior to December 6, 2019 ("Group 1 Cases"), Plaintiffs shall serve completed Plaintiff Profile Forms (updated version),

executed authorizations (updated versions), and responsive materials by December 30, 2019. For cases filed or transferred after December 6, 2019, the Plaintiff Profile Form (updated version), executed authorizations (updated versions), and responsive materials shall be served within sixty (60) days of the filing of the Defendants' Answer or by December 30, 2019, whichever is later.

c. Pursuant to the agreement of the parties, all Plaintiff Profile Forms and corresponding authorizations, along with any responsive documentation, shall be completed, signed where applicable, and served electronically to NJPROCEEDMCL@butlersnow.com and proceedmcl@fleming-law.com.

d. Every Plaintiff is required to provide Defendants with a Plaintiff Profile Form that is substantially complete in all respects to the best of the Plaintiff's knowledge, answering every question in the Plaintiff Profile Form, even if a Plaintiff can answer the questions in good faith only by indicating "not applicable." If a Plaintiff is suing in a representative or derivative capacity, the Plaintiff Profile Form shall be completed by the person with the legal authority to represent the estate or person under legal disability.

e. The Plaintiff Profile Form shall be completed without objections as to the question posed in the agreed upon Plaintiff Profile Form. This section does not prohibit a Plaintiff from withholding or redacting information from medical or other records provided with the Plaintiff Profile Form based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, Plaintiff shall provide defendants with a privilege log that complies with the Rules

Governing the Courts of the State of New Jersey simultaneously with the submission of the Plaintiff Profile Form.

f. Contemporaneous with submission of the Plaintiff Profile Form, each Plaintiff shall transmit via email or FTP upload (excluding DropBox), copies or electronic files of all medical records in their possession, custody, or control (including any medical records in their attorney's possession) related to the claims and/or alleged injuries in their case, including, but not limited to, records that support product identification.

g. Contemporaneous with submission of the Plaintiff Profile Form, each Plaintiff shall transmit via email or FTP upload (excluding DropBox), signed authorizations, which are attached to the Plaintiff Profile Form. The medical records authorizations may be used for the collection of records up to fifteen (15) years prior to the date of the implantation of the Proceed product at issue in this litigation, inclusive. In a particular case, if Defendants require records more than 15 years before implant, Plaintiff's attorney shall provide such a release unless the Court orders otherwise upon Plaintiff's motion. Plaintiffs who are not making a claim for lost wages, lost earning capacity, and/or lost future earnings, and have so represented in writing, do not need to sign or return the authorizations related to IRS records, employment records, or education records. Plaintiffs who are making a claim for lost wages, lost earnings capacity, and/or lost future earnings must complete and return the IRS Form 8821 and IRS Form 4506. If a plaintiff receives any communication from the IRS relating to either Form 8821 or Form 4506, that plaintiff shall promptly forward such communications to his/her/their

counsel, who shall coordinate with Defense Counsel to expeditiously remediate any deficiencies or issues impeding the collection of the requested tax return copies. Plaintiffs who have not applied for or receive Medicare benefits due to age, disability, condition or any other reason or basis, and have so represented in writing, do not need to submit a CMS authorization. Plaintiffs who have not applied for or receive Social Security Disability benefits (SSI or SSD), and have so represented same in writing, do not need to submit a signed Social Security Administration (SSA) release. If an individual Plaintiff is not claiming mental anguish which necessitated psychiatric treatment due to alleged Proceed Mesh injuries and not claiming that (s)he sought mental health treatment (including treatment for anxiety/depression) due to alleged Proceed Mesh injuries, then that Plaintiff is not required to sign or return the psychiatric authorization; provided however, that Defendants reserve the right to request such an authorization to collect such records if they have a good faith basis to believe such records should be produced in that case.[1]

h. The signed authorizations shall be undated and the recipient line shall be left blank. These blank, signed authorizations constitute permission for a third-party records vendor retained by the parties to obtain the records specified in the authorizations from the records custodians. In the event an institution, agency, or medical provider to which a signed authorization is presented refuses to provide responsive records, the individual Plaintiff's attorney shall attempt to resolve the issue with the institution, agency, or medical provider such that the necessary

[1] Refer to CMO 13, entered on August 20, 2020, which clarifies and establishes the scope of the obligation to produce executed authorizations for the release of mental health records.

records are promptly provided. Any records that pertain to psychiatric related care, whether by a psychiatrist or psychologist, shall first be available to counsel for the Plaintiff who shall have 20 days to assert a recognized discovery objection and/or privilege and notify both the vendor and counsel for the requesting Defendants, with an appropriate documentation of the discovery objection with specific reference(s) to page(s) and/or portion(s) thereof and/or a privilege log, in accordance with (Revised) Case Management Order No. 4 (Records Collection), which superseded CMO 4 entered on 8/20/2019. Absent notification within 20 days of the assertion of such an objection or privilege, the vendor shall then provide the records to the requesting Defendants. Signing an authorization for release of mental health treatment records shall not constitute waiver of any claim of discovery objection or privilege or any other legal protection for such records under applicable law. The provisions of Revised Case Management Order No. 4 (Records Collection) shall apply to such records. The authorizations provided by Plaintiff become null and void when his or her case is resolved, and any use of the authorizations beyond that date is prohibited.

i. The Plaintiff Profile Form will not be interpreted to limit the scope of inquiry at depositions nor will it affect whether evidence is admissible at trial. The admissibility of information in the Plaintiff Profile Form is governed by the New Jersey Rules of Evidence, and objections to admissibility are not waived by virtue of the completion and service of a Plaintiff Profile Form.

j. Plaintiff is under a continuing obligation to timely supplement or amend Plaintiff Profile Forms and responsive documentation.

k. In any case where a deposition of the Plaintiff is scheduled, Plaintiff must submit any supplement and/or amendments, to the extent applicable and to the extent the material is within the Plaintiff's or his/her attorney's possession, at least 21 days before the date of Plaintiff's deposition. If the Plaintiff's deposition is set to occur in less than 21 days from the time it is scheduled, then Plaintiff shall submit any such supplements and/or amendments as soon as practicable but no less than 5 business days before the date of Plaintiff's deposition.

l. Any Plaintiff who undergoes revision surgery or other surgical procedure related to the claims at issue in the case after completing and serving a Plaintiff Profile Form must complete and serve an updated Plaintiff Profile Form (including providing any additional responsive documentation) within 90 days after the date of the surgery or 90 days after Plaintiff's counsel becomes aware of such surgery or procedure, whichever is later.

m. Any Plaintiff who fails to fully comply with the requirements above shall be provided notice of such failure by email from Defendants' Counsel to all counsel of record on the case, and shall be provided 14 additional days to cure such deficiency ("Cure Period") to be calculated from the receipt of such notice of deficiency from counsel for the Defendants. If Defendants' notice of failure is related to a deficiency regarding information provided in the Plaintiff Profile Form, as opposed to Plaintiff's failure to provide a Plaintiff Profile Form whatsoever, Defendants shall state with particularity in Defendants' notice to Plaintiff why Defendants believe the information in the Plaintiff Profile Form is

deficient. Defendants shall also be required to make themselves available by email or phone to meet-and-confer to clarify any alleged information deficiencies.

n. ***Any Request for an extension of time to serve the Plaintiff Profile Form, authorizations and responsive documents and/or any request for an extension of the deficiency cure period should be submitted to Defendants via email to NJPROCEEDMCL@butlersnow.com.***

o. ***If a Plaintiff fails to cure a deficiency within the Cure Period set forth in section m. above, Defendants may seek permission to file a Motion to Compel (if Plaintiff Profile Form information deficiency) or a Motion to Dismiss (if Plaintiff has failed to provide a Plaintiff Profile Form).***

p. Plaintiff shall thereafter have 14 days to file a Response to the Motion and show good cause why the information is sufficient, the case should not be dismissed, and/or why less drastic sanctions other than dismissal are warranted. Defendants may file a Reply Brief within 7 days of Plaintiff's Response. ***Any failure by Plaintiff to respond to the Motion within the specified period shall result in dismissal of the case.***

q. This Case Management Order shall apply to each member related case previously transferred to, or filed in this Court. In cases subsequently filed in this Court, it shall be the responsibility of the Parties to review and abide by all pretrial Orders previously entered by the Court. The Orders may be assessed through the New Jersey State Court Electronic Filing System.

HONORABLE JOHN C. PORTO, J.S.C.

EXHIBIT A
To CMO 6
(Third Amended)

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER CASE NO. ATL-L-794-19

IN RE PROCEED MESH LITIGATION
(Proceed® Surgical Mesh and Proceed® Ventral Patch Hernia Mesh)

CASE NO. 630
Civil Action

PLAINTIFF PROFILE FORM

In completing this Plaintiff Profile Form, you must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

I. CASE INFORMATION

Caption:_____ **Docket No.:** _____

Primary Attorney Contact (name, address, phone, and email):

_____

II. PLAINTIFF INFORMATION

Name of Individual with Proceed_____ ❑**Male** ❑**Female**

Date of birth:_____ **Last 4 Digits of Social Security No.:** _____

Address:_____

Occupation: _____

Spouse Name: _____ **Loss of Consortium Claim?** ❑**Yes** ❑**No**

Name of Estate Representative if Individual Implanted with Proceed is Deceased: _____

**** Please submit the death certificate and letter of administration/representation if the individual implanted with Proceed is deceased.

III. PROCEED MESH DEVICE & IMPLANT AND REVISION INFORMATION

Date of Implant: _____

Reason You Believe Proceed was Implanted: _____

Lot Number: _____

Implanting Surgeon: _____

Medical Facility Name & Last Known Address:

_____

For each Proceed implant, submit the implant operative report and any medical evidence of product identification (product ID sticker).

Date of Surgery: _____

Description of Surgery: _____

Explanting/Revision Surgeon:

_____

Medical Facility Name & Last Known Address:

_____

Date of Surgery: _____

Description of Surgery: _____

Explanting/Revision surgeon:

_____

Medical Facility Name & Last Known Address:

_____

For each removal/revision, submit the operative report, any pathology report, and any medical evidence identifying the product removed/revised.

***Attach additional pages as needed to identify other responsive implant or removal/revision procedures.

IV. OUTCOME ATTRIBUTED TO DEVICE

A. Describe in detail the injuries, including any emotional or psychological injuries, that you claim resulted from the implantation of Proceed:

B. Please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries listed above.

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

***Attach additional pages as needed to describe injuries or identify other responsive health care providers.

C. Other than the Proceed product(s) that is the subject of your lawsuit, have you ever been implanted with any other hernia mesh products? **[ ] Yes [ ] No**

If Yes, please provide the following information:

1. Product Name(s) and Lot Numbers:

2. Date of implantation procedure(s) and name and address of implanting doctor(s) and implant procedure facility(ies):

**** Please submit all implant report(s) and product Identification Documentation for any implants listed in C. above.

D. Have you filed a lawsuit or asserted any claim related to any of the hernia mesh products listed in Section C? ❑Yes ❑No ❑N/A

If Yes, identify the claim/lawsuit asserted, the court, docket number, the date the claim/lawsuit was made,: _____

E. If any other products listed in Sections C. or D. above have currently pending claims in **This Court**, please provide the following additional information:

1. Describe in detail the injuries, including any emotional or psychological injuries, that you claim resulted from the implantation of any other mesh product subject to claims in This Court:

2. Have any other products listed in Sections C. or D. above with claims currently pending in This Court been revised or removed? **[ ] Yes [ ] No**

   a. If yes, identify when revised/removed and your understanding as to the reason for the revision/removal:

**** Please submit all operative report(s) and pathology records, if any, showing the removal or revision.

3. To the extent not already listed in Section B. above, please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries subject to claims in This Court:

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

4. Are you making a claim for lost wages, lost earning capacity, and/or lost future earnings?

❑Yes ❑No

If yes, please describe in detail the lost wages, earning capacity or future earnings you are claiming:

_____

_____

5. To the best of your knowledge, have you been approved to receive or are you receiving Medicare benefits due to age, disability, condition or any other reason or basis?*

❑Yes ❑No ❑Do Not Know

If yes, please specify the date on which you first became eligible:_____

(*If the answer is NO, you do not need to return the CMS (Medicare) release).

[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.]

6. Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the last 10 years to present?**

❑Yes ❑No

If yes, please specify the following:

a. Date (or year) of application:_____

b. Type of benefits sought: (check all applicable):
___ Workers' Compensation ___ Social Security Disability** ___ Other (please describe type of benefits sought):

c. Agency/Insurer from which you sought the benefits:

_____

d. The nature of the claim and specific injuries/disability alleged:

_____

e. Whether claim was accepted or denied:_____

f. Whether you are currently receiving any benefits as a result of the claim:

_____

g. Identify the name and address of the entity most likely to have records concerning your claim:_____

h. If applicable, the name and address of your employer against whom the claim was filed:_____

(** If you have not applied for or received Social Security Disability benefits, you do not need to sign and return the Social Security Administration (SSA) release.)

AUTHORIZATIONS AND MEDICAL RECORDS TO BE PRODUCED

Submit ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

Submit a copy of any medical records in your possession, custody, or control (including any medical records in your attorney's possession) related to the claims and/or alleged injuries in this case.

Signed this _____ day of _____ 20__

_____

Plaintiff's Counsel of Record
Firm Name
Firm Address
Firm Address 2
Phone
Email

EXHIBIT A to PPF

AUTHORIZATION AND CONSENT
TO RELEASE RECORDS AND PROTECTED HEALTH INFORMATION
(Excluding 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

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers' Claims

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

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to **Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124**; and their authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, dentists and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results, genetic testing information, and alcohol and drug abuse treatment) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all dental records, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic, hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

The undersigned also authorizes the disclosure of all records, reports, files, documents, correspondence, memoranda and all other information related to employment of the undersigned, including attendance reports, performance reports, W-2 and W-4 forms, medical reports and/or any and all other records relating to my past and present employment, and all educational records, including all courses taken, degrees obtained, and attendance records.

Further, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

The above list of types of records and other information to be disclosed is intended to be illustrative and not exhaustive. 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. Ethicon Inc., 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 either to **Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102 and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124:** 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 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 re-disclosure 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 furnished to Butler Snow, LLP; Riker, Danzig, Scherer, Hyland & Perretti LLP; and/or Litigation Management, Inc., pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ *v. Ethicon, Inc., et al.,* and is subject to re-disclosure 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).
- I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for drug or alcohol abuse, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, Sickle Cell Anemia, Tuberculosis and Genetic testing and counseling.
- I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of _____ **v. *Ethicon, Inc., 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 Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962¬1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; Litigation Management, Inc., 6000 Parkland Blvd,. Mayfield Heights, OH 44124; and/or and their 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 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

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers' Claims

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

The undersigned individual hereby authorizes each entity included in any of the above categories to furnish and disclose **to Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124**; and their 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. Ethicon, Inc., 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 **Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and/or Litigation Management, Inc., 6000**

Parkland Blvd., Mayfield Heights, OH 44124, 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 re-disclosure 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 furnished to Butler Snow, LLP, Riker, Danzig, Scherer, Hyland & Perretti LLP, McCarter & English, and/or Litigation Management, Inc. pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ _____ *v. Ethicon, Inc., et al* and is subject to re-disclosure 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 later of: (i) the date of settlement or final disposition of _____**v. *Ethicon, Inc., 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 Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124 and their 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").

Form **882**

Rev. February 2020)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ Go to *www.irs.gov/Form8821* for instructions and the latest information.
▶ Don't sign this form unless all applicable lines have been completed.
▶ Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you.

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone
Function
Date

1 Taxpayer information. Taxpayer must sign and date this form on line 7.

Taxpayer name and address	Taxpayer identification number s)	
	Daytime telephone number	Plan number if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached ▶** ☐

Name and address	CAF No.
	PTIN
	Telephone No.
	Fax No.
	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☐ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

a) Type of Tax Information Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	b) Tax Form Number 1040, 941, 720, etc.)	c) Year s) or Period s)	d) Specific Tax Matters

4 Specific use not recorded on Centralized Authorization File CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ▶ ☐

5 Disclosure of tax information you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☐

Note: Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you don't want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☐

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization s) that you want to retain . . . . . ▶ ☐

To revoke a prior tax information authorization s) without submitting a new authorization, see the line 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, partnership representative or designated individual, if applicable), executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature _____ Date _____

Print Name _____ Title if applicable) _____

Form **4506**

(March 2019)

Department of the Treasury
Internal Revenue Service

equest for opy of Tax eturn

▶ **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 abie 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.

Litigation Management Inc 6000 Parkland Blvd. Mayfield Heights Ohio 44124 888 803-8706

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	50.00
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 S-2 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.

CAUTION *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 5a. 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.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

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)

_____

_____

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

- ☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

3. **Check only one 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 reason for the disclosure (you may write "at my request"):**

Litigation

5. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

Name Litigation Management Inc

Address 6000 Parkland Blvd, Mayfield Heights, OH 44124

Name _____

Address _____

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

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. To revoke authorization, send a written request to the address noted below. 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.

6. **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: _____

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

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

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

Print Form

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 authorization, send a written request to the address noted 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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:**

LITIGATION MANAGEMENT, INC.

***ADDRESS OF PERSON OR ORGANIZATION:**

6000 PARKLAND BOULEVARD

MAYFIELD HEIGHTS, OH 44124

***I want this information released because:** to be used in support of an active litigation.

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

Invoices can be sent via fax to: 440-484-2055, please reference the PacketID number found above Social Security Disability on the request letter.

Please feel free to contact Litigation Management, Inc. directly at (888) 803 - 8706 with any questions.

***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 PRESENT.
5. ☒ My Medicare entitlement from date _____ to date PRESENT.
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.)

   Documents or other items relating to my social security claims(s): applications, questions, petitions, payment documents/decisions/awards/denials, jurisdictional documents/notes, transcripts, correspondence, findings, notice of hearings, hearing records, orders, depositions, reports; witnesses, medical reviewers and experts consultative examination reports, current developments/temporary, non-disability development and documentation, medical records and determination records.

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)