FILED

October 16, 2023

HON. BRUCE J. KAPLAN, J.S.C.

IN RE: ZOSTAVAX® LITIGATION

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: MIDDLESEX COUNTY

CASE NO. 629

CASE MANAGEMENT ORDER #36
SEPTEMBER 26, 2023
CASE MANAGEMENT CONFERENCE

THIS MATTER, having come before the Court at a Case Management Conference on September 26, 2023 and counsel for plaintiffs and counsel for defendants having been present, and for good cause having been shown;

IT IS on this 16th day of October, ORDERED as follows:

1. **GROUP B CASE POOL: AUTHORIZATIONS**

   All Group B plaintiffs identified in Exhibit A of the Case Management Order: First Amended Bellwether Scheduling Order-Group B dated July 13, 2023 that have not been selected as a Group B Bellwether Discovery Case shall produce fully executed authorizations, as identified in Exhibit A, to Merck's counsel by November 10, 2023.

2. **GROUP B BELLWETHER POOL: REPLACEMENT CASES**

   a. The following plaintiffs were selected as replacement cases for the Group B Bellwether Pool and shall provide fully executed authorizations by October 5, 2023.

      - Bilinski, Vickie (MID-L-007925-20)
      - Miley, Suzanne (MID-L-000042-21)
      - Stepneski, Melody (MID-L-000831-20)

b. Jenson, John (MID-L-004891-19) has been selected as a replacement case for the Group B Bellwether Pool and has provided executed authorizations.

c. If the Charles Still case (MID-L-002952-20) is dismissed with prejudice, the Melody Stepneski case (MID-L-000831-20) shall become a permanent replacement case in the Group B Bellwether Pool.

3. NEXT CASE MANAGEMENT CONFERENCE

The next Case Management Conference is scheduled for November 1, 2023 at 9:00 A.M. via zoom with a link to be provided by the Court. The liaison counsel meeting is scheduled for October 25, 2023 at 9:00 A.M. via zoom with a link to be provided by the Court.

/S/ Bruce J. Kaplan

The Honorable Bruce Kaplan, J.S.C.

EXHIBIT A

AUTHORIZATION TO DISCLOSE
EMPLOYMENT INFORMATION AND RECORDS

To: _____

Name: _____

DOB: _____ SSN: _____

I, hereby authorize and request the Custodian of Records at the above-named entity to disclose to Venable LLP and/or Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights OH 44124, any and all records containing employment information, including those that may contain protected health information (PHI).

Records requested may include, but are not limited to:

> all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held, and any other records concerning employment with the above-named entity.

This authorization does allow the release of mental health or other psychiatric records, unless this box is checked. ☐

Unless revoked in writing, this authorization shall be valid for the period 4 years from the date of this authorization. The purpose of this request is in support of litigation.

1. **I understand that information in my health records 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.**

2. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**

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

4. **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI will no longer be protected by 45 CFR Section 164, Subpart E.**

5. **A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.**

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information to those persons or entities listed above.

Date: _____

_____
(Signature) Employee or Employee Representative

_____
Printed Name of Employee's Representative

_____
Description of Representative's authority to act for employee/relationship to employee (if applicable)

Employee's Name and Address:

_____

_____

MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:

Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:

Address:

City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

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

Select **one** option:
- ☐ Release **all** records to date
- ◉ Release records in timeframe from start date _____ to end date: _____

NY residents only:
- ☐ Include all records
- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

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

Select **one** option:
- ☐ One-time disclosure
- ☐ Expiration upon specified date _____
- ◉ Expiration upon specified event Upon conclusion of litigation

SECTION C: RELEASE INFORMATION TO

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

☐ Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name	Recipient 1 Email Address
Litigation Management Inc	records@lmi-med.com

Recipient 1 Mailing Address:

7976 Mayfield Rd., Suite 150, Chesterland, OH 44026

SECTION D: PURPOSE FOR REQUEST

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

☐ At the request of the individual	▪ Litigation

SECTION E: AUTHORIZATION AGREEMENT

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

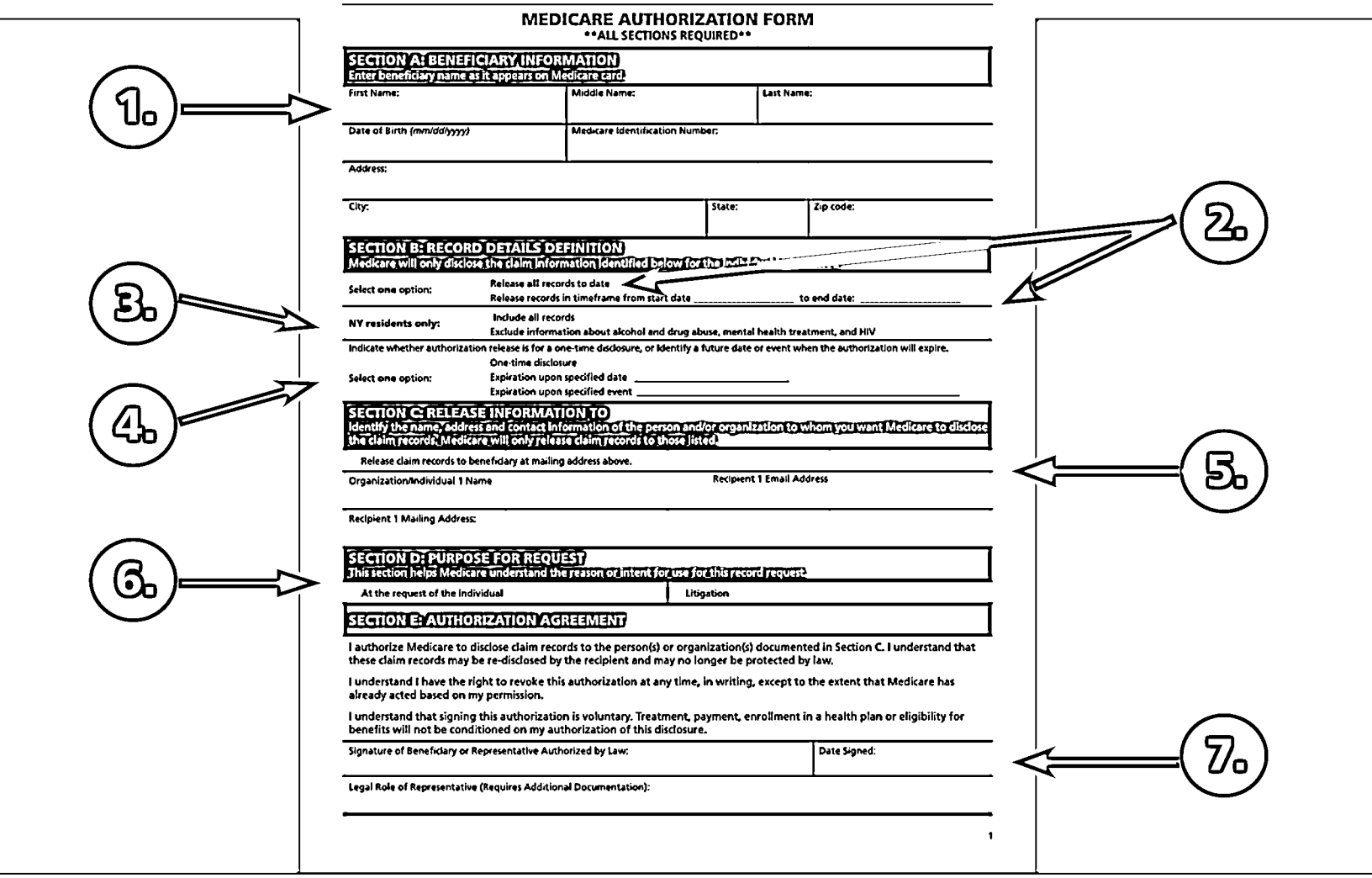
I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

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

Signature of Beneficiary or Representative Authorized by Law:	Date Signed:

Legal Role of Representative (Requires Additional Documentation):

Reset All Check Fields



1. **BENEFICIARY INFORMATION**
   Add beneficiary name and ID number as printed on Medicare identification card, date of birth, and address.
2. **RECORD TIMEFRAME**
   Indicate date range of records to release, or select "release all records."
3. **NY RESIDENTS: EXCLUSIONS OPT-IN**
   (NY residents only) Specify whether to exclude records related to alcohol and drug abuse, mental health treatment, and HIV.
4. **SELECT EXPIRATION DATE OR EVENT**
   Indicate date or event information release authorization will expire, if you are not requesting a one-time disclosure.
5. **SPECIFY ORGANIZATION TO RELEASE TO**
   Specify individual(s) to whom records should be released. First name, last name, and address are required. Additional contact information provided will be used only to follow up on questions related to your application submission.
6. **SELECT REASON FOR REQUEST**
   Select purpose for record release request to help Medicare understand how records will be used.
7. **BENEFICIARY SIGNATURE**
   Signature and date by beneficiary or authorized representative in acceptance of HIPAA clauses required to release information. If form not signed by beneficiary, attach notarized Power of Attorney (living individual), or Letters Testamentary and/ or Letters of Administration from the court (deceased individual).

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND OTHER RECORDS

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 1996)

TO _____

Patient Name: _____

DOB _____

SSN: _____

I, hereby authorize you to release and furnish to Venable LLP and/or Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights, OH 44124, copies of the following information:

* All available medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.

* This authorization does allow the release of mental health or other psychiatric records, unless this box is checked. ☐

* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.

* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

* All Worker's Compensation records and disability records.

* All billing records including all statement, itemized bills, and insurance records.

* All employment records, including attendance reports, performance reports, W-4 forms, W-2 forms, medical reports and/or any and all other records relating to my employment, past and present.

* All records containing educational information, including those that may contain protected health information, and including any and all school records, application and admission paperwork, attendance records, transcripts, diplomas, health and physical examination records, immunization records, nurse's notes, disciplinary records, and correspondence.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for purposes of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that information in my health records 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.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will remain in effect until 4 years from the date of this authorization. I have a right to receive a copy of this authorization.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment or eligibility or enrollment for benefits. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Date: _____

_____
(Signature) Patient or Patient Representative

_____
Printed Name of Patient's Representative

_____
Description of Representative's authority to act for patient/relationship to patient (if applicable)

Patient's Name and Address:

_____

_____

_____

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

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: _____

This will authorize you to furnish copies of all available forms regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, records, notes or invoices and bills, which may be in your possession, including those that may contain protected health information (PHI).

This authorization does allow the release of mental health or other psychiatric records, unless this box is checked. ☐

Name of Insured: _____

DOB: _____ SSN: _____

You are authorized and requested to release the above records to Venable LLP and/or Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights, OH 44124, who have agreed to pay reasonable charges made by you to supply copies of such records.

Unless revoked in writing, this authorization shall be valid for the period 4 years from the date of this authorization. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof, if is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Signature: _____

Printed Name: _____

Date: _____