RESET FORM

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: AVANDIA MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION

Master Docket No.

MDL No. 1871

THIS RELATES TO:
MDL Case No._____

Plaintiff:_____
(name)

AVANDIA®
PLAINTIFF FACT SHEET

Each plaintiff who suffered personal injury as a result of taking AVANDIA®, AVANDARYL®, and/ or AVANDAMET®, hereinafter collectively referred to as Avandia, must complete this Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. As to healthcare providers, please include name, address, and telephone number in the section entitled "Medical Providers and Other Sources of Information" herein. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. This Fact Sheet is being completed with the assistance of counsel.

If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. Please attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

A. Please state the following for the civil action that you filed:

1. Case caption:_____

2. Civil Action Number:_____

3. Court in which action was originally filed:_____

4. Your attorney:
   Name:_____
   Firm: _____
   Address:_____
   _____
   Telephone Number:_____Fax Number:_____
   E-mail Address:_____

B. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. Maiden or other names you have used or by which you have been known and dates you used those names:

_____

2. Your Current Address:

_____

3. The individual or estate you are representing, and in what capacity you are representing the individual or estate:

Individual/Estate You Represent:_____
Capacity:_____

4. If you were appointed as a representative by a court, state the:

Court Which Appointed You:_____
Date of Appointment:_____

5. What is your relationship to the individual or decedent you represent?

_____

6. If you represent a decedent's estate, state:

Date of Death:_____
Place Where Decedent Died:_____

_____

THE REMAINDER OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USED AVANDIA®. IF YOU ARE COMPLETING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE AVANDIA® USER

II. CLAIM INFORMATION

A. Do you claim that you suffered bodily injury as a result of taking AVANDIA®?
Yes_____ **No** _____ If **Yes**, please answer the following:

1. What bodily injury/injuries do you claim resulted from your use of AVANDIA®?

_____

_____

2. When is the first time you saw a health care provider for any of the symptoms you link to your alleged injury?

3. Are you currently experiencing symptoms related to your alleged injury? Yes _____ No_____

If yes, describe symptoms:_____

4. Did you see a doctor, clinic or healthcare provider for the bodily injuries or illness listed above?
_____ **Yes** _____ **No** _____ **I don't know**

If **Yes**, who: _____

[The full name and address of this, and other doctors, clinics or healthcare providers must be provided in Section X of this Fact Sheet]

5. Who diagnosed your injury? _____

6. Date of diagnosis?_____
Your age at diagnosis:_____

7. Were you hospitalized?_____
Yes_____ **No** _____ If **Yes**, please answer the following:

a. Date of hospital admission:_____
b. Date of discharge:_____
c. Hospital name and address:_____
_____

8. What harm or consequences do you claim you suffered as a result of the injury?
_____
_____
_____

B. 1. Did you ever suffer this type of bodily injury before the date set forth in answer to the prior question?

_____ **Yes** _____ **No**

If **Yes**, when and who diagnosed the condition at the time?_____
_____

2. Do you claim that AVANDIA® worsened a previously existing injury/ condition?
Yes_____ **No** _____ If **Yes**, set forth the injury/ condition, whether or not you had already recovered from that injury/ condition before you took AVANDIA®, and, if so, the date you previously recovered from the injury/ condition:
_____
_____

3. Have you had any discussions with any doctor or other healthcare provider about whether AVANDIA® contributed to your bodily injury or illness?
_____ **Yes** _____ **No** _____ **I don't recall**

If **Yes**, who: _____

C. Are you claiming mental and/or emotional injury as a result of taking AVANDIA®? **Yes**_____ **No** _____ If **Yes**, what mental and/or emotional injury do you claim resulted from your use of AVANDIA®?

_____

_____

If **Yes**, for each healthcare provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, as a result of taking AVANDIA®, state the following:

Name	**Address**	**Condition treated**	**Dates treated**	**Medications prescribed**

D. Are you making a claim for lost wages or lost earning capacity? **Yes**_____ **No** _____ If **Yes**, state the annual gross income you derived from your employment for three (3) years before and after your injury:

_____

_____

_____

E. Are you are making a claim for out of pocket expenses as a result of taking AVANDIA®? _____ **Yes** _____ **No**

If **Yes,** please describe the amount and what the expenses were for:_____

_____

III. AVANDIA® PRESCRIPTION INFORMATION

A. Prescriber and Pharmacy Information:

1. Who prescribed AVANDIA® for you?_____

2. Name of pharmacies where prescriptions were filled (please provide addresses in Section X): _____

_____

3. For what condition were you prescribed AVANDIA®: _____

_____

B. Identify the following for each period of time during which you took AVANDIA®

Medication: (Avandia, Avandamet, Avandaryl)	**Dosage (2 mg, 4 mg or 8 mg)**	**How often per day**	**Date Started**	**Date Stopped**

C. Did you receive any samples of AVANDIA®?
Yes _____ **No** _____ If **Yes**, please state the following:

1. Who provided the samples?_____

2. When were samples provided?_____

3. Did you propose to any healthcare provider that he or she prescribe you AVANDIA® **Yes** _____ **No** _____

If **Yes**, which healthcare provider(s): _____

D. Instructions or Warnings: Did you receive any written and/or oral information about AVANDIA®? **Yes**_____ **No** _____ **I don't recall** _____

If **Yes**, please specify:_____

Information Received	**Written or Oral**	**When Received**	**From Whom Received**

E. Have you ever visited a website, chat-room, message board or other electronic forum containing information or discussion about AVANDIA®?

Yes_____ **No** _____ **I don't recall** _____

If **Yes,** please provide the names of the website(s):_____

IV. MEDICAL BACKGROUND

A. Height: _____

B. Weight immediately before first AVANDIA® use:_____

C. Weight at time of injury: _____

D. Current Weight:_____

E. During the 5 years prior to your alleged injury, did you engage in any regular exercise?

Yes_____ **No**_____

If **Yes**: a. Type of exercise _____

b. How often (# of times per week) _____

F. After your alleged injury, have you engaged in any regular exercise? **Yes**_____ **No**_____

If **Yes**: a. Type of exercise _____

b. How often (# of times per week) _____

G. Has any healthcare provider advised you to follow a restricted diet? **Yes**_____ **No**_____

If **Yes**, describe the nature of the dietary restrictions and the date of advice regarding diet _____
_____

H. Tobacco Use History: Check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/ or chewing tobacco/ snuff.

_____ I have never used tobacco.

_____ I used tobacco in the past

Date tobacco use started:_____ Date tobacco use ceased:_____

Amount used: on average _____ per day for _____ years

_____ I currently use tobacco

Date tobacco use started:_____

Amount currently using: on average _____ per day for_____ years

_____ I have used different amounts of tobacco at different times (please identify type (s) of tobacco used and dates of use below).

_____

I. Alcohol Consumption: Did you drink alcohol (beer, wine, etc.) in the three years before your alleged injury? **Yes**_____ **No** _____

If Yes, fill in the appropriate blank with the number of drinks that best represents your average alcohol consumption during that time:_____drinks per week;_____drinks per month; _____ drinks per year; or

Other (describe): _____

J. Illicit Drugs: Have you used (even one time) any illicit drugs of any kind within five (5) years before, or at any time after, your time AVANDIA® related injury?

Yes_____ **No** _____ If **Yes**, identify the substance (s) and your first and last use:

_____

K. Within the five (5) days leading up to your injury, had you undergone any surgery?

Yes_____ **No** _____ If **Yes**, identify the surgery:

_____

L. At the time of your injury, were you performing any strenuous activity in which you did not routinely engage?

Yes_____ **No** _____ If **Yes**, please describe:

_____

M. For **women** only: within the month leading up to your injury, were you using either birth control pills or hormone replacement therapy?

Yes_____ **No** _____ If **Yes**, please describe:

_____

N. To the best of your knowledge, have you, or any blood-relative family member (child, parent, brother, sister, or grandparent), ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please identify who suffered the condition, you or a relative, and please provide the relative's name and relationship to you. If you suffered the condition, please provide the additional information requested in the table following this chart:

Condition Experienced or That Was Diagnosed	**Y**	**N**	**Who Suffered Condition: You or Relative**
1. DIABETES CONDITIONS / DISEASES			
a. Diabetes (Type 1)			
b. Diabetes (Type 2)			
c. Diabetic Coma			
d. Diabetic ketoacidosis (DKA)			
e. Gestational Diabetes			
f. Glycosuria/glucosuria (sugar in urine)			
g. Hyperglycemia (high blood sugar)			
h. Hyperinsulinism (excessive amount of Insulin)			
i. Hypoglycemia (low blood sugar)			
j. Impaired fasting glucose, pre-diabetes			
k. Insulin resistance			
l. Ketonemia (ketones in blood)			
m. Ketonuria (ketones in urine)			
n. Matabolic syndrome			
o. Polydipsia (excessive thirst)			
p. Polyphagia (excessive hunger or appetite)			
q. Polyuria (excessive urine output)			
2. CARDIOVASCULAR CONDITIONS/DISEASES			
a. Acute Coronary Syndrome (ACS)			
b. Aneurysm			
c. Angina (including stable angina, unstable angina and variant angina)			
d. Arteriosclerosis/athersclerosis (hardening, narrowing or blocking or arteries), atherosclerotic heart disease			
e. Arteriovenous malformation (AVM)			
f. Arrythmia, abnormal heart rhythm, irregular heartbeat, bradycardia, tachycardia, atrial fibrillation, ventricular fibrillation			
g. Blood clots, blood disorders			
h. Cardiac hypertrophy (enlarged heart)			
i. Cardiomyopathy			
j. Cardiovascular disease or death			
k. Carotid artery disease			
l. Cerebrovascular disease (stroke), brain attack, hemorrhagic stroke, ischemic stroke, intracranial hemorrhage, subarachnois hemorrhage			
m. Chest pain/pressure			
n. Congenital heart abnormality or condition			
o. Congestive heart failure (CHF), heart failure			
p. Coronary artery disease, coronary heart disease			

Condition Experienced or That Was Diagnosed	Y	N	Who Suffered Condition: You or Relative
q. Hypertension (high blood pressure), hypertensive crisis			
r. Ischemia, myocardial ischemia			
s. Myocardial Infarction (heart attack)			
t. Peripheral vascular disease, poor circulation			
u. Plasma volume expansion			
v. Systolic dysfunction, diastolic dysfunction			
w. Transient Ischemic Attack (TIA)(mini-stroke)			
x. Valvular heart disease, heart valve problem, mitral regurgitation			
y. Vascular disease			
3. CHOLESTEROL/LIPID CONDITIONS			
a. Abnormal cholesterol, high cholesterol			
b. Elevated triglycerides, hypercholesterolemia, hyperlipidemia			
4. EYE DISEASES/CONDITIONS			
a. Blurred vision			
b. Macular edema, retinopathy			
5. KIDNEY DISEASES/CONDITIONS			
a. Kidney disease, kidney failure, renal failure			
b. Nephropathy, albuminuria, proteinuria			
6. PULMONARY (lung) DISEASES			
a. Chronic Obstructive Pulmonary Disease (COPD)			
b. Dyspnea (difficult breathing), shortness of breath			
c. Lung ailments (lung disease, cor pulmonale, emphysema, asthma)			
d. Pulmonary embolism, Deep Vein Thrombosis (DVT)			
e. Pulmonary Hypertension, pulmonary arterial hypertension, primary pulmonary hypertension			
7. OTHER DISEASES			
a. Alcoholism/drug addiction			
b. Allergic rection to medication			
c. Autoimmune disease			
d. Biliary tract disease			
e. Bone fractures			
f. Cancer			
g. Eating disorders (anorexia, bulimia)			
h. Edema, fluid retention, water retention, ankle swelling			
i. Gastrointestinal problems (ulcers, heartburn, GERD)			
j. Lactic acidosis			
k. Liver disease (including hepatocellular or cholestatic disorder)			
l. Metabolic acidosis			
m. Migraine headaches			
n. Mumps			
o. Neuropathy, peripheral neuropathy			
p. Obesity			

O. For each condition for which you answered **Yes** as to **you** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Condition Experienced	Date of Onset	Medication/ Treatment	Treating Physician

V. DIABETIC CONDITION

A. Have you been diagnosed with diabetes? Yes_____ No_____

1. How old were you (age) _____, and when were you diagnosed with diabetes?_____

2. What type of diabetes were you diagnosed with?
_____Type I or insulin dependent _____Type II or non-insulin dependent
_____Type II treating with insulin _____Other (describe) _____

B. By whom first diagnosed?

_____

Name

_____

C. Which medications used to treat diabetes have you taken? (If you do not know or do not recall, please indicate in the appropriate column)

Medication	Yes/ No/ Do Not Recall	Dosage	Date First Taken	Date Last Taken
1. Glitazones (other than AVANDIA®)				
Actos	Yes___ No___ Do not Recall___			
Rezulin	Yes___ No___ Do not Recall___			
2. Biguanides				
Glucophage	Yes___ No___ Do not Recall___			
Metformin	Yes___ No___ Do not Recall___			
Fortamet	Yes___ No___ Do not Recall___			
3. Alpha-glucosidase Inhibitors				
Glyset	Yes___ No___ Do not Recall___			
Precose	Yes___ No___ Do not Recall___			

Medication	Yes/ No/ Do Not Recall	Dosage	Date First Taken	Date Last Taken
4. Meglitinides				
Prandin (Repaglinide)	Yes___ No___ Do not Recall___			
Starlix (Nateglinide)	Yes___ No___ Do not Recall___			
5. Insulin				
Lispro (Humalog)	Yes___ No___ Do not Recall___			
Regular	Yes___ No___ Do not Recall___			
Premixed	Yes___ No___ Do not Recall___			
Ultralente	Yes___ No___ Do not Recall___			
NPH or Lente	Yes___ No___ Do not Recall___			
Glargine/ Lantus	Yes___ No___ Do not Recall___			
Glulinine	Yes___ No___ Do not Recall___			
Levemir (Detemir)	Yes___ No___ Do not Recall___			
6. Sulfonylureas				
Amaryl (Glimepiride)	Yes___ No___ Do not Recall___			
DiaBeta (Glyburide)	Yes___ No___ Do not Recall___			
Dymelor	Yes___ No___ Do not Recall___			
Glucotrol (Glipizide)	Yes___ No___ Do not Recall___			
Glucotrol XL	Yes___ No___ Do not Recall___			
Glynase PresTab	Yes___ No___ Do not Recall___			
Micronase	Yes___ No___ Do not Recall___			
Orinase	Yes___ No___ Do not Recall___			
Tolinase	Yes___ No___ Do not Recall___			
Other (specify)	Yes___ No___ Do not Recall___			
7. Amylin Mimetics				
Symlin (Pramlintide)	Yes___ No___ Do not Recall___			
8. DPP-4 Inhibitors				
Januvia (Sitagliptin)	Yes___ No___ Do not Recall___			
9. Incretin Mimetrics				
Byetta (Exenatide)	Yes___ No___ Do not Recall___			
10. Other (specify)				
	Yes___ No___ Do not Recall___			

VI. CARDIOVASCULAR CONDITION

A. Please indicate whether you have ever received any of the following treatments or procedures and provide the requested information about each.

1. **Cardiovascular Surgeries**. This includes but is not limited to open heart/ bypass surgery, CABG, pacemaker or defibrillator implantation, stent placement, vascular surgery, angioplasty, IVC filter placement, carotid (neck artery) surgery, or valve replacement.

Yes_____ **No** _____ **I don't recall** _____ If **Yes**, please specify:

Surgery	Condition	Date	Treating Physician	Hospital

2. Treatment for heart attack, angina (chest pain), or lung ailments (other than as described in your response to question 1 above):

Yes_____ **No** _____ **I don't recall** _____ If **Yes**, please specify:

Treatment	Date	Treating Physician	Hospital

3. **Cardiovascular Diagnostic Tests**. This includes but is not limited to stress test, PET scan, MUGA scan, Pulmonary Function test, ADA risk test, C-reactive protein (CRP), chest X-ray, angiogram/ catheterization, CT scan, MRI, EKG, echocardiogram, TEE (trans-esophageal echo), endoscopy, lung bronchoscopy, carotid duplex/ ultrasound, MRI/MRA of the head/ neck, angiogram of the head/ neck, CT scan of the head, bubble/ microbubble study, and Holter monitor.

Yes_____ **No** _____ **I don't recall** _____ If **Yes**, please specify:

Diagnostic Test	**Reason for Test**	**Date**	**Treating Physician/ Hospital**	**Result of Diagnostic Test**

VII. MEDICATION

A. Using the table below, please circle/underline those medications that you have taken in the past 10 years and provide the dates you took the medication, the doctor(s) who prescribed it, and the pharmacy where the prescription was filled.

Medication	**Dates Taken**	**Prescribing Doctor**	**Pharmacy Where Obtained**
1. BETA BLOCKERS: Acebutolol (Sectral); Atenolol (Tenormin); Bisoprolol (Zebeta); Carvedilol (Coreg); Esmolol (Brevibloc); Labetalol (Normodyne, Trandate); Metropolol (Lopressor, Toprol XR); Propanolol (Ideral); Other beta blockers (please specify)			
2. CORTICOSTEROIDS: Prednisolone (Prednisolone, Medrol, Prelone); Prednisone (Deltasone, Prednicen-M, Sterapred); Triamcinolone (Aristocort, Kenacort); Other corticosteroids (please specify)			
3. INJECTABLE CONTRACEPTIVES: Medroxyprogesterone (Depo-Provera); Medroxyprogesterone and estradiol (Lunelle); Other injectable contraceptives (please specify)			

4. THIAZIDE DIURETICS AND RELATED DIURETICS: Chlorothiazide (Diuril, HydroDiuril); Hydrochlorothiazide (Microzide); Indapamide; Metolazone (Mykrox, Zaroxylyn); Polythiazide (Renese); Other thiazide or thiazide-related diuretics (please specify)			
5. PROTEASE INHIBITORS: Amprenavir (Agenerase); Indinavir (Crixivan); Lopinavir (Kaletra); Nelfinavir (Viracept); Ritonavir (Norvir); Saquinavir (Fortovase, Invirase); Other protease inhibitors (please specify)			
6. COX-2 INHIBITORS: Valdecoxib (Bextra); Celecoxib (Celebrex); Rofecoxib (Vioxx)			
7. STATINS: Lovastatin (Mevacor); Simvastatin (Zocor); Pravastatin (Pravachol); Fluvastatin (Lescol); Atorvastatin (Lipitor); Rosuvastatin (Crestor); Other statin medicine (please specify)			
8. NITRATES: Glyceryl trinitrate (nitroglycerine) (Anginine tablets, Glytrin Spray, Minitran patches, Nitrocor patches, Nitro-Dur patches, Nitroderm TTS patches, Nitroderm TTS patches, Nitrolingual pump spray, Rectogesic ointment, Transiderm-Nitro patches); Sodium Nitroprusside Isosorbide Mononitrate (Corangin, Duride, Imdur Durules, Imtrate SR, ISMO 20, Isomonit, Monodur); Isosorbide Dinitrate (Coronex, Isordil, Sorbidin); Other nitrate medicine (please specify)			
9. ANTIPSYCHOTIC AGENTS: Aripiprazole (Abilify); Clozapine (Clozaril); Quetiapine (Seroquel); Risperodone (Risperdal); Amisulpride (Solian); Chlorpromazine (Thorazine); Haloperidol (Haldol); Olanzapine (Zyprexa); Perphenazine (Trilafon); Thiothixine (Navane); Trifluoperazine (Stelazine); Other antipsychotic agents (please specify)			
10. MOOD STABILIZERS: Carbamazepine (Tegretol, Epitol); Divalproex (Depakote); Lithium (Lithane, Lithobid, Lithonate, Lithotabs); Valproate (Depakene Syrup); Other mood stabilizers (please specify)			
11. ANTIDEPRESSANTS: Bupropion (Wellbutrin, Wellbutrin SR); Citalopram hydrobromide (Celexa); Clomipramine (Anafril); Despiramine (Norpramin); Doxepin (Sinequan); Fluoxetine (Prozac); Fluoxetine and olanzapine (Symbyax); Imipramine pamoate (Tofranil-PM); Mirtazpine (Remeron); Nefazadone (Serzone); Paroxetine (Paxil, Paxil CR); Protriptyline (Vivactil); Setraline (Zoloft); Trimipramine (Surmontil); Venlaxafine (Effexor, Effexor XR); Other antidepressants (please specify)			
12. ORAL CONTRACEPTIVES: Estrogen/Progestic combination pills (Brevicon, Levlen, Levora, Modican, Nelova, Nordette, Norethin, Norinyl, Ortho-Novum, Ovcon, Tri-Levlen); Progestin only pills (Mictonor, Nor-QD)			

C. Please tell us whether you have regularly taken (for more than sixty (60) days) any other medications in the past ten (10) years, including over the counter medications and dietary supplements. If you answer **Yes** for any medication, please indicate whether you recall ever taking that medication on a daily basis for more than two months at a time and/or if you were taking the medication while also taking AVANDIA®.

Name of Medication	For What Condition	Daily Use for More than Two Months? (Yes or No)	Taking With Avandia? (Yes or No)

D. Have you ever experienced any side effects while you were taking any of the medications identified in this section in the past ten (10) years?

Yes_____ **No** _____ If **Yes**, please state the following:

Name of Medication	Side Effects	Date(s) Experienced

VIII. PERSONAL INFORMATION

A. Name: _____

B. Maiden or other names by which you have been known and dates used:

_____

C. Current Address:_____

_____

D. How long have you been living at this address:_____

E. Social Security Number:_____

F. Date and City of Birth:_____

G. Gender: Male _____ Female _____

H. If you have a driver's license, please provide the state of issuance and number: _____

I. List any prior addresses at which you have lived during the last ten (10) years, and the dates you resided at each one.

Prior Address	Dates

J. Please complete the following for each school you attended after High School, if applicable.

School Name	Address	Dates Attended	Diplomas or Degrees

K. Work Experience: Identify the following for each employer (including self-employment) you have had in the last ten (10) years:

Name of Employer	Address	Dates of Employment	Occupation/ Job Duties

L. Military Service: Have you ever served in the military, including the military reserve or National Guard? **Yes**_____ **No** _____

If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical condition? **Yes**_____ **No** _____

If **Yes**, state the condition for which you were rejected or discharged:

_____

M. Insurance / Claim Information

1. Has any insurance or other company, or Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the prior ten (10) years?

Yes_____ **No** _____ If **Yes**, please complete the following:

Name of Company or Governmental Agency	**Address**	**Dates of Service**

2. Have you applied for workers' compensation (WC) and/or social security disability (SSI or SSD) benefits in the last ten (10) years?
Yes_____ **No** _____ If **Yes**, please state the following:

Type of Claim: WC or SSI or SSDI	**Year Application Filed**	**Agency Where Application Filed**	**Nature of Disability**	**Time Period of Disability**

3. Have you filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit, relating to any bodily injury?
Yes_____ **No** _____ If **Yes**, please state the following:

Court in Which Suit Filed/ Claim Made	**Case/ Claim Number**	**Nature of Claim and Injury**

N. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?
Yes_____ **No** _____ If **Yes**, please set forth where, when, and the felony and/ or crime:

_____

IX. FAMILY INFORMATION

A. Marriage(s)

1. If you are or have ever been married, identify the following:

Spouse's Name	**Date Married**	**Date of End of Marriage**

2. Has your spouse filed a claim for loss of consortium in this action?
Yes_____ **No** _____

B. If you have children, please list each child's name and date of birth:

_____

_____

_____

X. MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

A. Identify each doctor or other healthcare provider who has provided treatment to you in the past ten (10) years for any reason (attach additional sheets as needed).

Name	Address	Approximate Dates	Reason

B. Identify each hospital where you have had any surgical procedure during the last ten (10) years. Please also identify the surgical procedure performed and the physician that treated you.

Name of Hospital	Address	Admission Date(s)	Surgical Procedure	Name of Physician

C. Identify each hospital, clinic, or healthcare facility where you have received inpatient or outpatient treatment or been admitted as a patient for any reason, other than surgery, during the last ten (10) years (attach additional sheets as needed).

Name	Address	Admission Date(s)	Reason for Admission

D. Identify each pharmacy that has dispensed medication to you for any reason in the last ten (10) years (attach additional sheets as needed).

Name of Pharmacy	Address of Pharmacy

XI. DOCUMENTS

Please provide a copy of all your documents and things that fall in to the categories below, which are in your possession, or that you gave to your attorney. If you claim a legal privilege regarding any document or item listed below, please attach a privilege log to your Fact Sheet.

A. Records and bills of physicians, hospitals, pharmacies, other healthcare providers, government agencies, insurance companies, or any other entities identified in response to this Fact Sheet.
B. Decedent's death certificate (if applicable).
C. Report of autopsy of decedent (if applicable).
D. Letters of Testamentary or Letters of Administration relating to your status as plaintiff.
E. Any copies of the packaging, including the bottle, box, and label for AVANDIA®.
F. Prescriptions or receipts for AVANDIA®.

G. If you are claiming lost wages or a loss of earning capacity, your W-2 forms and/ or 1099 forms for each of the years starting three (3) years prior to the time you allege you first suffered lost wages or a loss of earning capacity through the present.

H. If you have been the claimant or subject to any workers' compensation, Social Security, or other disability proceeding, all documents relating to such preceding for the prior ten (10) years.

I. Copies of any documents that you obtained from any source (other than your lawyer) relating to Avandia, including, but not limited to, documents obtained from your physician, pharmacy, newspapers, magazines and the internet.

J. Any electronic mail relating to Avandia.

XII. ACKNOWLEDGEMENT

By submission of this Fact Sheet, Claimant acknowledges that Claimant has an obligation to preserve materials (including, but not limited to, paper documents, electronically stored information, tissue samples and other biological evidence) relating to Claimant's claim. Claimant further acknowledges that Claimant is subject to the MDL 1871 Court's jurisdiction, any of the Court's orders regarding preservation of documents, things or electronically stored information relevant to Claimant's claim, and any agreements negotiated with defendant SmithKline Beecham Corporation dba GlaxoSmithKline regarding the preservation of such materials.

Signature: _____ Date: _____

XIII. AUTHORIZATIONS

Complete and sign the attached Authorizations for Release of Medical Records (HIPAA) and, if you are alleging a loss of earning capacity, the attached Authorization for Release of Employment Records (which includes workers' compensation (WC) records.

If you have filed a Social Security Disability claim, please complete and sign the attached Authorization directed to Social Security Disability.

CERTIFICATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Plaintiff Fact Sheet is true, complete and correct to the best of my knowledge, that I have supplied all the documents requested in "Documents." of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. Further, I acknowledge that I must supplement my responses if I learn that they are incomplete or incorrect in any material respect.

Signature: _____ Date: _____

RESET FORM

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: AVANDIA MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	§	**MDL 1871**
	§	**2:07-md-01871-CMR**
	§	**HON. CYNTHIA M. RUFE**
THIS DOCUMENT RELATES TO ALL ACTIONS	§	

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")

TO: _____
Name of Healthcare Provider/Physician/Facility

_____
Address

_____
City, State and Zip Code

RE: Patient Name: _____
Date of Birth:_____ Social Security Number:_____-_____-_____
Address:_____
_____

I, _____, hereby authorize you to release and furnish to: _____, copies of full and complete protected medical information, including the following:

For use in the In Re: Avandia Marketing, Sales Practices and Products Liability Litigation, MDL 1871(CMR). To my healthcare provider: *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.

- 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 billing information, including insurance records and Medicare/Medicaid claims applications.

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 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 expire at conclusion of individual plaintiff litigation.

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. I understand I may inspect or copy the information to be used or disclosed as provided in 45 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 indicate above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

_____ _____

Signature of Patient or Personal Representative **Witness Signature**

_____ _____

Dated Dated

_____

Name of Patient or Personal Representative

_____

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

This authorization is valid only for records from _____

Name of Healthcare Provider/Physician/Facility

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: AVANDIA MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	§	**MDL 1871**
	§	**2:07-md-01871-CMR**
	§	**HON. CYNTHIA M. RUFE**
THIS DOCUMENT RELATES TO ALL ACTIONS	§	

AUTHORIZATION FOR THE RELEASE OF MENTAL HEALTH RECORDS
PURSUANT TO 45 CFR 164.508(a)(2) (HIPAA)

TO: _____
Name of Healthcare Provider/Physician/Facility
_____
Address
_____
City, State and Zip Code

RE: Patient Name: _____
Date of Birth:_____ Social Security Number:_____ _____ _____
Address:_____
_____

I, _____, hereby authorize you to release and furnish to: _____, copies of full and complete protected medical information, including the following:

For use in the In Re: Avandia Marketing, Sales Practices and Products Liability Litigation, MDL 1871(CMR). To my healthcare provider: *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- All psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:
    - All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, records received by other physicians, pharmacy and prescription records, billing records and records of billing to third party payers and payment or denial of benefits.

This protected health information is disclosed for the following purposes: The currently pending litigation involving the person named above.

This authorization is given in compliance with 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

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

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

I acknowledge that I have the right to revoke this authorization by written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.
I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.
This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

I understand that the nature of this authorization is to authorize the release of my mental health records.

_____
Signature of Patient or Personal Representative

_____
Dated

_____
Name of Patient or Personal Representative

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

_____
Witness Signature

_____
Dated

This authorization is valid only for records from _____
Name of Healthcare Provider/Physician/Facility

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: AVANDIA MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	§	**MDL 1871**
	§	**2:07-md-01871-CMR**
	§	**HON. CYNTHIA M. RUFE**
THIS DOCUMENT RELATES TO ALL ACTIONS	§	

LIMITED AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Including Mental Health Records)

TO: _____
Name

_____
Address

_____
City, State and Zip Code

RE: Patient Name: _____
Date of Birth:_____ Social Security Number:_____-_____-_____
Address:_____
_____

I, _____, hereby authorize you to release and furnish to: _____, copies of full and complete protected medical information, including the following:

For use in the In Re: Avandia Marketing, Sales Practices and Products Liability Litigation, MDL 1871(CMR). *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- Copies of all applications for employment, unemployment benefits, resumes, records of all positions held, job descriptions of *positions* held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, psychiatric, nurse and dental records, x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to my employment with the above-named institution, including records for treatment of psychological, psychiatric or emotional problems concerning

_____
Name of Employee

whose date of birth is _____ and whose social security number is _____.

I understand that the information in my employment and unemployment 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.

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

_____

Name of Representative

_____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____

Street Address

_____

City, State and Zip Code

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 your records custodian. 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 expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this employment and unemployment information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 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 employment and unemployment information, I can contact the releaser indicate above.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

_____ _____

Signature of Patient or Personal Representative **Witness Signature**

_____ _____

Dated Dated

_____

Name of Patient or Personal Representative

_____

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

This authorization is valid only for records from _____

Name

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff's Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: AVANDIA MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	§	**MDL 1871**
	§	**2:07-md-01871-CMR**
	§	**HON. CYNTHIA M. RUFE**
THIS DOCUMENT RELATES TO ALL ACTIONS	§	

LIMITED AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Excluding Mental Health Records)

TO: _____
Name

_____
Address

_____
City, State and Zip Code

RE: Patient Name: _____
Date of Birth:_____ Social Security Number:_____-_____-_____
Address:_____
_____

I, _____, hereby authorize you to release and furnish to: _____, copies of full and complete protected medical information, including the following:

For use in the In Re: Avandia Marketing, Sales Practices and Products Liability Litigation, MDL 1871(CMR). *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- Copies of all applications for employment, unemployment benefits, resumes, records of all positions held, job descriptions of *positions* held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, nurse and dental records, x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to my employment with the above-named institution.

_____
Name of Employee

whose date of birth is _____ and whose social security number is _____.

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

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

_____

Name of Representative

_____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____

Street Address

_____

City, State and Zip Code

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 your records custodian. 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 expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this employment and unemployment information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 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 employment and unemployment information, I can contact the releaser indicate above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

_____ _____

Signature of Patient or Personal Representative **Witness Signature**

_____ _____

Dated Dated

_____

Name of Patient or Personal Representative

_____

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

This authorization is valid only for records from _____

Name

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff's Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: AVANDIA MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	§	**MDL 1871**
	§	**2:07-md-01871-CMR**
	§	**HON. CYNTHIA M. RUFE**
THIS DOCUMENT RELATES TO ALL ACTIONS	§	

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Including Mental Health Records)

TO: _Social Security Disability_____

_____
Address

_____
City, State and Zip Code

RE: Patient Name: _____
Date of Birth:_____ Social Security Number:_____-_____-_____
Address:_____
_____

I, _____, hereby authorize you to release and furnish to: _____, copies of full and complete protected medical information, including the following:

For use in the In Re: Avandia Marketing, Sales Practices and Products Liability Litigation, MDL 1871(CMR). *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- All Social Security Disability records.
- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- 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 billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits.

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 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 expire at conclusion of individual plaintiff litigation.

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. I understand I may inspect or copy the information to be used or disclosed as provided in 45 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 indicate above.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

_____ _____

Signature of Patient or Personal Representative **Witness Signature**

_____ _____

Dated Dated

_____

Name of Patient or Personal Representative

_____

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

This authorization is valid only for records from <u>Social Security Disability</u>

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: AVANDIA MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	§	**MDL 1871**
	§	**2:07-md-01871-CMR**
	§	**HON. CYNTHIA M. RUFE**
THIS DOCUMENT RELATES TO ALL ACTIONS	§	

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Excluding Mental Health Records)

TO: _Social Security Disability_____

_____
Address

_____
City, State and Zip Code

RE: Patient Name: _____
Date of Birth:_____ Social Security Number:_____-_____-_____
Address:_____
_____

I, _____, hereby authorize you to release and furnish to: _____, copies of full and complete protected medical information, including the following:

For use in the In Re: Avandia Marketing, Sales Practices and Products Liability Litigation, MDL 1871(CMR). *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- All Social Security Disability records.
- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- 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 billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits.

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 treatment for alcohol and drug abuse.

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 expire at conclusion of individual plaintiff litigation.

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. I understand I may inspect or copy the information to be used or disclosed as provided in 45 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 indicate above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

_____ _____

Signature of Patient or Personal Representative **Witness Signature**

_____ _____

Dated Dated

_____

Name of Patient or Personal Representative

_____

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

This authorization is valid only for records from <u>Social Security Disability</u>