AUTHORIZATION FOR RELEASE OF PAYROLL AND PERSONNEL RECORDS

TO WHOM IT MAY CONCERN:

The undersigned authorizes you to provide to_____ _____, a complete copy of all records pertaining to my employment, including but not limited to all personnel, payroll, medical, hospital, workmen's compensation, or insurance records.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Name: _____

Date of Birth: _____

Social Security Number: _____

_____
SIGNATURE

_____
DATE

STATE OF _____

COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____ known to me to be the person whose name is subscribed to the foregoing authorization and who, after being by me duly sworn, upon oath states that same was executed for the purpose therein expressed.

SUBSCRIBED and SWORN to before me, a Notary Public, on the _____ day of _____, 2010.

_____
NOTARY PUBLIC

My Commission Expires;_____

Exhibit A

AUTHORIZATION FOR RELEASE OF INFORMATION AND DOCUMENTS PERTAINING TO BANKRUPTCY TRUSTS

NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE YOU TO PROVIDE TO THE FIRM OF _____ _____ AND THEIR REPRESENTATIVES, A COMPLETE COPY OF ALL DOCUMENTS RELATING OR PERTAINING TO CLAIMS MADE BY ME TO ANY ASBESTOS BANKRUPTCY TRUST. SAID DOCUMENTS SHALL INCLUDE, BUT NOT BE LIMITED TO, ALL CLAIM FORMS, EMPLOYMENT RECORDS, PRODUCT IDENTIFICATION RECORDS AND MEDICAL RECORDS SUBMITTED IN SUPPORT OF SAID CLAIM.

I HAVE CAREFULLY READ AND UNDERSTAND THIS AUTHORIZATION AND DO HEREIN EXPRESSLY AND VOLUNTARILY AUTHORIZE THE DISCLOSURE OF THE ABOVE LISTED INFORMATION AND DOCUMENTS TO THE FIRM OF _____

_____

Signature of Individual or Representative

_____

Printed name of Individual

_____

Relationship of Representative to Individual

_____

Description of Representative's Authority to Act for the Individual

Exhibit B

AUTHORIZATION FOR RELEASE OF EDUCATIONAL AND VOCATIONAL RECORDS

TO WHOM IT MAY CONCERN:

I hereby authorizes you to provide the law firm of _____ _____, and its representative, or assign, a complete copy of all information and/or documents pertaining to myself.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Name: _____

Date of Birth: _____

Social Security Number: _____

_____
SIGNATURE

or

_____
PERSONAL REPRESENTATIVE

STATE OF _____

COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____ _, known to me to be the person whose name is subscribed to the foregoing authorization and who, after being by me duly sworn, upon oath states that same was executed for the purpose therein expressed.

SUBSCRIBED and SWORN to before me, a Notary Public, on the _____ day of _____, 2009.

_____
NOTARY PUBLIC

My Commission Expires;_____

EXHIBIT C

AUTHORIZATION FOR RELEASE OF CRIMINAL RECORDS

TO WHOM IT MAY CONCERN:

This authorization shall require any and all penal institutions, including but not limited to, all prisons, jails, police offices, sheriff's offices, district attorney's offices, and parole offices to produce the following law firm of _____

_____, and its duly authorized representative:

Any and all information, including but not limited to, my criminal record, arrest warrants, arrest records, conviction records, and parole records.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Name: _____

Date of Birth: _____

Social Security Number: _____

_____
SIGNATURE

or

_____
PERSONAL REPRESENTATIVE

STATE OF _____

COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing authorization and who, after being by me duly sworn, upon oath states that same was executed for the purpose therein expressed.

SUBSCRIBED and SWORN to before me, a Notary Public, on the _____ day of _____, 2009.

_____
NOTARY PUBLIC

My Commission Expires:_____

EXHIBIT D

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial) SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

EXHIBIT E-1

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send this form or requests for benefits to this address.**

TO	Department of Veterans Affairs	NAME OF INDIVIDUAL *(Type or print)*	
		VA FILE NO. *(Include prefix)*	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶	NAME

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

NOTE: Additional information may be listed on the reverse side of this form.

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)*	DATE

VA FORM OCT 1995(R) **3288**

AdobeFormsDesigner

EXHIBIT E-2

Department of Veterans Affairs

INFORMATION REGARDING POSSIBLE CLAIM AGAINST THIRD PARTY

TO	ADDRESS OF VA FACILITY **District Counsel (02)**	FROM	NAME AND ADDRESS OF VA FACILITY

VETERAN'S NAME *(Last, First, Middle Initial)*	TELEPHONE
VETERAN'S ADDRESS *(Number, Street, City, State, Zip Code)*	SOCIAL SECURITY NUMBER
	DATE OF THIS REPORT
NAME OF PERSON FURNISHING THIS INFORMATION, *If other than veteran (Last, First, Middle Initial)*	TELEPHONE

ADDRESS OF PERSON FURNISHING THIS INFORMATION *(If other than veteran)*

NATURE OF INJURY OR DISEASE

REIMBURSABLE INSURANCE *(INSURANCE COMPANY + ADDRESS, POLICY NUMBER: TYPE OF COVERAGE: GROUP OR INDIVIDUAL)*

IF CLAIM OR CAUSE OF ACTION IS AGAINST A THIRD PARTY; GIVE NAME AND ADDRESS OF SUCH PARTY

☐ TORT-FEASOR ☐ CRIMES OF PERSONAL VIOLENCE

☐ WORKER'S COMPENSATION ☐ "NO FAULT" INSURANCE

HAS VETERAN SUBMITTED CLAIM ORALLY OR IN WRITTING ☐ YES ☐ NO	IF SUBMITTED TO THAN THIRD PARTY NAMED ABOVE, TO WHOM AND WHEN WAS IT SUBMITTED

NAME, TELEPHONE NUMBER AND ADDRESSES OF WITNESSES

GIVE DATE, TIME, EXACT LOCATION AND DESCRIPTION OF INCIDENT WHICH RESULTED IN INJURY

WHAT AUTHORITIES, IF ANY, CONDUCTED INVESTIGATION OF INCIDENT

HAS VETERAN CONTACTED ATTORNEY ☐ YES ☐ NO	NAME AND ADDRESS OF ATTORNEY REPRESENTING VETERAN *(If applicable)*

REMARKS

VA FORM JUNE 2007 **10-1023**

EXHIBIT E-3

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

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

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

____ Social Security Number
____ Identifying information (includes date and place of birth, parents' names)
____ Monthly Social Security benefit amount
____ Monthly Supplemental Security Income payment amount
____ Information about benefits/payments I received from _____ to _____
____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
____ Medical records
____ Record(s) from my file (specify) _____
____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury 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 gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)
Date: _____ Relationship: _____

Form SSA-3288 (3-2005) EF (3-2005)

EXHIBIT F

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

   Print the Name, Social Security Number (SSN), and date of birth below.

   Name _____ Social Security Number _____

   Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

   ☐ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

   _____

   _____

   ☐ **Certified Total Earnings For Each Year.** (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ _____

   Do you want us to certify the information? ☐ Yes ☐ No

   If yes, enter $15.00 . . . . . B. $ _____

   ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ _____

   - You can pay by CREDIT CARD by completing and returning the form on page 4, or
   - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
   - DO NOT SEND CASH.

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

   SIGN your name here (Do not print) > _____ Date _____

   Daytime Phone Number _____ _____
   (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

   Name _____ Address _____

   City, State & Zip Code _____

6. Mail Completed Form(s) To:

   Social Security Administration
   Division of Earnings Record Operations
   P.O. Box 33003
   Baltimore Maryland 21290-3003

   Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

   Social Security Administration
   Division of Earnings Record Operations
   300 N. Greene St.
   Baltimore Maryland 21290-0300

EXHIBIT G

AUTHORIZATION TO OBTAIN UNION TRADE, SKILL AND/OR PROFESSIONAL ORGANIZATION MEMBERSHIP DOCUMENTS AND RECORDS

TO:

The undersigned requests that you release to the law firm of _____ _____, or such other person ast it may authorize, at their expense, all records relating to my union, trade, skill and/or professional organization membership and/or involvement, including but not limited to information, applications, or other documents signed by me, medical records, letters, memoranda, and transcripts of proceedings.

The undersigned agrees to waive any privilege against disclosure which I might have under the laws of Mississippi but reserves the right to object to the admissibility of such record in any proceeding in any court and/or administrative proceedings.

The undersigned agrees that a photostatic copy of this Authorization to Obtain Union Records shall have the same force and effect as the original.

Name: _____

Date: _____

Social Security Number: _____

_____
SIGNATURE

or

_____
PERSONAL REPRESENTATIVE

STATE OF _____

COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing authorization and who, after being by me duly sworn, upon oath states that same was executed for the purpose therein expressed.

SUBSCRIBED and SWORN to before me, a Notary Public, on the _____ day of _____, 2009.

_____
NOTARY PUBLIC

My Commission Expires;_____

EXHIBIT H

Form **4506**

(Rev. October 2006)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.**

▶ **Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.**

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the 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 call 1-800-829-1040 to order a transcript.

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

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

4 Previous address shown on the last return filed if different from line 3

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. The IRS has no control over what the third party does with the tax return.

Caution: *DO NOT SIGN this form if a third party requires you to complete Form 4506, and lines 6 and 7 are blank.*

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 $57 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 or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 57.00
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 . . ☐

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, **either** husband or wife must sign. If signed by a corporate officer, partner, 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.

Sign Here

▶ **Signature (see instructions)**	**Date**	Telephone number of taxpayer on line 1a or 2a ( )
▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
▶ **Spouse's signature**	**Date**	

EXHIBIT I

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:
Address:
Phone:
Date of Birth:
SSN:

Regarding: _____ v. _____, Civil Action File/Case No: _____, _____ Court, State of ____ ("the Lawsuit")

I authorize the information to be disclosed to and used by the following individual and /or organization:

_____
_____
_____
_____

ATTN:
For the purpose of: a claim, lawsuit or arbitration proceeding.

Information to be Used or Disclosed:
I authorize any physician, hospital, health care provider, health facility, and governmental or private agency, including the Workmen's Compensation Commission, and each of them together with their respective employees and/or agents, to disclose my "protected health information" to Legal Counsel for _____ (defined below), as specified in this Authorization and set forth in privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule").

I understand that my protected health information includes any and all medical records, medical opinions if in writing, original x-rays, papers, notes and histories, pathology, tissue samples, cytology, blocks, slides, or other pathology specimens, or any other documents, records or papers concerning any past medical history and/or treatment, examinations, periods of hospitalizations or confinement, diagnoses, or any other information pertaining to and concerning my physical or mental condition and treatment or billing/payment information relating thereto. I understand "protected health information" also includes records disclosed to my health care providers by health care providers and facilities who previously provided treatment to me. I understand "protected health information" may also include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment or AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus). I specifically authorize the disclosure of any and all protected health information, opinions, records, medical records, medical history, consultation, prescription or treatment relating to my physical or mental health and relating to any referral, diagnosis or treatment for alcohol or drug use. I also specifically authorize the disclosure of any and all papers concerning any claim or claims which have been filed by me against any employer or employers before the Workmen's Compensation Commission, or any commission of any other state.

Exhibit J

This authorization permits only the copying of any and all papers, records, etc., **with the exception of x-rays and tissue samples, which must be produced in original form.** Original x-rays are required because of the nature of the claim I am making. X-ray copies cannot be interpreted for pneumoconiosis or other certain conditions, and therefore copies are not effective. Copies may be maintained by the hospital or other organization if deemed necessary, but the original x-rays must be turned over when a request for them is accompanied by this authorization.

Discussions with healthcare providers must be limited to the obtaining of materials and the scheduling of depositions, hearings, and trials. However, such healthcare providers are authorized by me to disclose and explain my protected health information during depositions, hearings, trials or other proceedings in the above Lawsuit.

Person(s) Authorized to Make the Use or Disclosure:
Any physician, hospital, health care provider, health facility, institution and governmental or private agency, including the Workmen's Compensation Commission, which possesses any of my protected health information is authorized to make the uses and disclosures specified in this authorization.

Recipient(s) of Use or Disclosure:
My protected health information may be used by or disclosed to the attorneys, consultants, experts, employees and other agents hired or employed by _____, or its legal counsel, in connection with, or for purposes of, _____ defense of the Lawsuit.

Purpose(s) of the Use or Disclosure:
The purpose of the use or disclosure is to provide my protected health information regarding my care and treatment, including information as to the claims and injuries I have asserted in the Lawsuit. I understand that production of my protected health information to the recipients is necessary to evaluate the claims and injuries I have asserted in the Lawsuit. I authorize the use of my protected health information in discovery, depositions, hearings, trials, and other proceedings in connection with the Lawsuit, and I understand such protected health information will be used only for purposes provided for herein. This authorization will expire at the close of litigation, including all appeals, for the Lawsuit.

I understand I may revoke this Authorization by submitting a written revocation to _____, who shall forward such revocation to those persons or facilities from whom my protected health information has been requested in connection with the Lawsuit. However, such revocation will not be effective with respect to any use or disclosure made in reliance on this Authorization before the person or entity making the disclosure received my revocation. I understand that health care providers and facilities cannot condition my treatment on whether or not I sign this Authorization.

I understand my protected health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipients, in which case it might no longer be protected under the HIPAA Privacy Rule.

This authorization is continuing in nature and maintains full force and effect for use in obtaining my protected health information dated both before and after the date of this document. A photocopy of this authorization shall have the same force and effect as the original, and the parties authorized to use, disclose, or receive my protected health information hereunder may rely on it as if it were.

Print Patient Name	Patient Social Security Number
Patient Signature	Date of Signature

Or

Personal Representative of Patient	Date of Signature

Basis of Personal Representative's authority to sign for patient: _____

Note: A copy of the signed Authorization must be provided to Patient.

STATE OF)
) ss.
COUNTY OF)

Subscribed and sworn to before me this ____ day of _____, 2009 by

_____
Notary Public

My commission expires:

Standard Form 180 (Rev. 09/08) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))

Authorized for local reproduction
Previous edition unusable

OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy.** When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☐ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, provide facility name and date for each admission:

☐ **Other** (Specify):

2. **PURPOSE:** (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain:

1. **REQUESTER IS:** *(Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above

☐ Next of kin of deceased veteran (Must provide proof of death).
Show relationship: _____
(See item 2a on accompanying instructions.)

☐ Legal guardian (Must submit copy of court appointment.)

☐ Other (specify) _____

2. **SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 4 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

3. **AUTHORIZATION SIGNATURE REQUIRED** *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature Required - Do not print

Date of this request ( ) Daytime phone

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

Exhibit K

Form 80-607

MISSISSIPPI

STATE TAX COMMISSION

REQUEST FOR RELEASE OF COPIES OF INDIVIDUAL INCOME TAX RETURNS

DATE: _____

I HEREBY AUTHORIZE YOU TO PROVIDE _____LIABILITY IN REGARD TO DISCLOSURE OF THE INFORMATION.

Social Security Number: _____ TAX YEAR(S): _____

_____

Name: _____

Address: _____

City, State, Zip: _____

Signature: _____

****

STATE OF _____ COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing authorization and who, after being by me duly sworn, upon oath states that same was executed for the purpose therein expressed.

SUBSCRIBED and SWORN to me, a Notary Public, on the _____ day of _____, 20____.

My Commission Expires:_____ _____

Notary Public Signature

The "Mississippi Public Records Act of 1983" requires the following charges be submitted before delivery of the reproduced documents. Payments **must** be in the form of cash, a cashier's check or money order. We **do not accept personal checks** for copies. We **do not** recommend you send cash through the mail. **The charge for copies is $2.00 for the first page and $.50 for each additional page.** We will return this document with the charge shown below. Please allow 10 days for processing to request.

**********FOR OFFICE USE ONLY**********

TOTAL NUMBER OF PAGES _____ **TOTAL COST** $_____

INITIAL & DATE DOCUMENTS COPIED:_____ INITIAL & DATE PAID: _____

Exhibit L-1

REQUEST FOR COPY OF STATE TAX FORM OR INDIVIDUAL INCOME TAX ACCOUNT INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize you to provide _____ _____, with any and all tax returns as specifically requested herein. This authorization is my consent to the release of said documents.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

_____

Tax Years Requested:

_____
SIGNATURE

_____
DATE

STATE OF_____

COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____ known to me to be the person whose name is subscribed to the foregoing authorization and who, after being by me duly sworn, upon oath states that same was executed for the purpose therein expressed.

SUBSCRIBED and SWORN to before me, a Notary Public, on the _____ day of _____, 2010.

_____
NOTARY PUBLIC

My Commission Expires;_____

Exhibit L-2

AUTHORIZATION FOR RELEASE OF WORKMAN'S COMPENSATION RECORDS

TO WHOM IT MAY CONCERN:

The undersigned authorizes you to provide _____

_____, a complete copy of all information and/or documents pertaining to myself.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Name: _____

Date of Birth: _____

Social Security Number: _____

_____
SIGNATURE

_____
DATE

STATE OF _____

COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing authorization and who, after being by me duly sworn, upon oath states that same was executed for the purpose therein expressed.

SUBSCRIBED and SWORN to before me, a Notary Public, on the _____ day of _____, 2010.

_____
NOTARY PUBLIC

My Commission Expires;_____

Exhibit M

AUTHORIZATION TO RELEASE INFORMATION

INJURED PARTY'S FULL LEGAL NAME: _____

SOCIAL SECURITY NUMBER: _____

MEDICARE NUMBER ("HICN"): _____

DATE OF BIRTH: _____

DATE OF INJURY[1]: _____

In compliance with the Federal Privacy Act of 1974 and Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), this authorizes the Centers for Medicare & Medicaid Services (CMS), and their contractors, to release to _____ ("Authorized Party"), or its representatives, any and all information concerning conditional payments made by Medicare to or on behalf of the above-named injured party resulting from the disease(s) of _____ which is/are alleged to have been caused by exposures to asbestos and or silicosis beginning on the above-mentioned date.

The undersigned also hereby authorizes the Authorized Party to disclose the injured party's Social Security number to CMS and its contractors.

The undersigned also hereby authorizes the Authorized Party to disclose the injured party's Social Security number to the Social Security Administration and Veterans Administration to determine disability benefits (for the purposes fo determining Medicare eligibility).

A copy of this form will have the same force and effect as the original. This form expires two years from the date of execution; however the undersigned may revoke this authorization by sending a request in writing at any time to the appropriate office below:

MSPRC
Liability
Post Office Box 33828
Detroit, MI 48232
Tel (866) 677-7220 Fax (734) 957-0998

SIGNED: _____ DATE:_____

If this form is executed by the legal representative of the estate of an injured party, complete below and attach proof of appointment as the representative of the estate (i.e. Letters Testamentary, Court Order, etc.).

Representative's Name (Printed): _____

[1] Date of injury in this instance is the date upon which the injured party is alleged to have been first exposed to asbestos and or silicosis at any location.

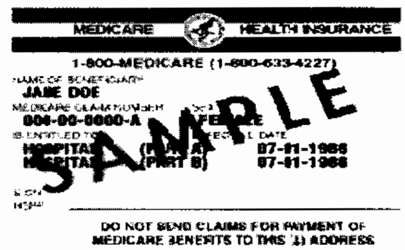
Exhibit N

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?		☐Yes	☐No
If yes, please complete the following. If no, proceed to Section II.			
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*			
Medicare Claim Number:		**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)*	- -	**Sex**	☐Female ☐Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Exhibit O

Section III

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form **Date**