UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: TYLENOL (ACETAMINOPHEN) MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION:	§	**MDL NO. 2436**
	§	**2:13-md-02436**
	§	**HON. LAWRENCE F. STENGEL**
	§	
	§	
	§	
THIS DOCUMENT RELATES TO ALL CASES	§	

CASE MANAGEMENT ORDER NO. 10
(Plaintiff and Defense Fact Sheet(s))

THIS ORDER shall govern all of the cases being litigated as part of MDL 2436. Accordingly, this Order applies to all cases assigned to this Court, whether by an original filing in this Court and assigned as related to MDL 2436, a removal from state court to this Court and assigned as related to MDL 2436, or by the entry of a Conditional Transfer Order by the Judicial Panel for Multidistrict Litigation assigning the case(s) to this Court as related to MDL 2436. The Parties, having consented, stipulated and agreed to the entry of this Case Management Order, and good-cause appearing therefore;

IT IS, on this 20th day of June, 2013, hereby **ORDERED** as follows:

I. PLAINTIFF FACT SHEET ("PFS")

1. **Form of Plaintiff Fact Sheet**: Each Plaintiff shall submit to Defense Counsel a completed Plaintiff Fact Sheet ("PFS") attached hereto as Exhibit "A" along with responsive documents and eight (8) completed authorizations as referenced below in Section III.

2. After the entry of this Order, Plaintiffs are not required to provide Defense Counsel with a separate Rule 16 Initial Disclosure because the PFS shall substitute for Plaintiffs'

Rule 16 Initial Disclosure.

3. Plaintiffs who, prior to the entry of this Order, provided records to Defense Counsel with a Rule 16 Initial Disclosure are not required to reproduce the same records with their PFS.

4. **Timing:** Plaintiffs shall serve Defense Counsel[1] with a completed PFS within the time frame set forth below:

a. As for cases pending in this Court as of the date of the entry of this Order, the Plaintiff in such cases shall serve the completed PFS on Defense Counsel **within sixty (60) calendar days** from the date of this Order, or,

b. For cases that are not currently pending before this Court as of the time of the entry of this Order, the Plaintiff in any case filed hereafter shall serve the completed PFS on Defense Counsel within **sixty (60)** calendar days of the date on which a case becomes docketed in this Court. A case does not become pending before this Court until it is docketed in this Court by reason of an original filling of the case in this Court, removal of the case from state court directly to this Court, or by transfer to this Court by the Judicial Panel for Multidistrict Litigation. The sixty (60) calendar days is calculated from the date on which service of process is made on the first Defendant as to cases that originate in this Court.

[1] As used herein, "Defense Counsel" shall mean counsel for Defendants of record identified on the Clerk of Court's docket in the named Plaintiffs' case. If a Defendant is represented by multiple counsel of different law firms, that Defendant shall designate which law firm is to receive the service of the completed PFS. Plaintiff need serve only one copy of the completed PFS on the designated law firm for each separate Defendant in the case.

As to a case that is removed to this Court from a state court, then sixty (60) calendar days is calculated from the date that the case is assigned as related to this Court after removal and docketed in MDL 2436. Similarly, as to cases that are transferred to this Court by the Judicial Panel for Multidistrict Litigation, the sixty (60) calendar days is calculated from the date that the case is transferred to this Court by the Panel as related and is received and docketed in this Court.

3. **Completed PFS:**

a. Each individual Plaintiff shall sign the Declaration attached to his/her respective PFS which signature shall be under penalty of perjury. Every Plaintiff is required to provide Defendants with a PFS that is substantially complete in all respects, answering every question in the PFS, even if a Plaintiff can answer the question in good-faith only by indicating "not applicable." If a Plaintiff is suing in a representative or derivative capacity, the PFS shall be completed by the person with the legal authority to represent the estate or person under legal disability. Plaintiff spouses with a claim of loss of consortium shall also sign the PFS, attesting that the responses made to the loss of consortium claim questions in the PFS are true and correct to the best of his or her knowledge, information and belief, formed after due diligence and reasonable inquiry.

b. A completed PFS shall be considered to be the equivalent of interrogatory answers and responses to requests for production of documents under the Federal Rules of Civil Procedure and submitted in lieu thereof. The interrogatories and requests for production in the PFS shall be fully answered without objection and will be governed by the standards applicable to written discovery under the Federal Rules of Civil Procedure.

c. The admissibility of information in a PFS shall be governed by the Federal Rules of Civil Procedure, the Federal Rules of Evidence, and applicable case law. No objections to admissibility are waived by virtue of any PFS response.

d. Notwithstanding the foregoing, nothing in this section prohibits a Plaintiff from withholding or redacting information based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, Plaintiff shall provide Defendants with a privilege log that complies with Rule 26(b)(5) simultaneously with the submission of the PFS, in accordance with CMO-9 that governs privilege logs. In the event that a dispute arises concerning the completeness or adequacy of a Plaintiff's response to any request contained in the PFS, this section shall not prohibit the Plaintiff from asserting that his or her response is adequate.

e. Contemporaneous with the submission of a PFS, each Plaintiff shall provide Defendants with hard-copies or electronic files of all

medical records in their possession or control to the extent not previously provided, particularly as to those Plaintiffs who may have provided such documents along with a Rule 16 Initial Disclosure or by reason of providing such information prior to the case being docketed in this Court as related to MDL 2436.

f. The completion of a PFS does not preclude the Defendants from serving additional non-duplicative discovery in accordance with the Federal Rules of Civil Procedure. Defendants will meet and confer with Plaintiffs and provide them with an advance copy of any additional non-duplicative discovery before serve it. Plaintiffs reserve the right to object to any additional discovery served by Defendants outside of the PFS.

4. **Service of a Completed PFS:**

a. In the alternative to sending the PFS by mail, a completed PFS may be E-mailed to Defense Counsel as follows:

- If to McNeil at kandice.haynes@butlersnow.com
- If to Novartis at msherry@gibbonslaw.com
- If to Perrigo at bgoodman@gdldlaw.com
- As to any other Defendant, *e.g.,* a Defendant not presently involved in this case as a Defendant, to the E-mail address indicated on the first pleading filed by any such Defendant in the Plaintiff's case.

5. **Confidentiality of Information in a PFS:** All information contained in the PFS is confidential and protected under the *Protective Order* (CMO-1).

II. AUTHORIZATIONS FOR THE RELEASE OF RECORDS

6. The completed authorizations that Plaintiffs are required to provide to Defense Counsel are described below and are appended to the PFS. As noted above, the PFS to be provided to Defendants' counsel is attached hereto as Exhibit "A". Defendants have represented that they have contracted with a record copy service vendor ("Defendants' Medical Record Service") to obtain copies of records. The parties will meet and confer to propose a separate Order that will outline the procedures and terms by which Defendants will make records collected by the service available to Plaintiffs. Plaintiffs shall provide the authorizations as described below with their completed PFS:

a. **Healthcare Authorizations**- For each medical provider identified in the PFS that Plaintiff has identified in Section III of the PFS, Plaintiff shall provide a completed and signed (but undated) *Healthcare Authorization* in the form attached to the PFS as Exhibit "A."

b. **Tax Return 4506 and 4506-T IRS Forms**- If the Plaintiff answers "Yes" to question 5 in Section VII in the PFS and is asserting a claim for lost wages or a reduction in lost earning capacity, the Plaintiff shall provide to Defendants a completed and signed IRS Form 4506 and 4506-T, which documents are attached to the PFS as Exhibit "B", for each year identified in Plaintiffs' answer to question 5 of Section VII of the PFS for which a claim of lost earnings or reduction in earnings capacity is asserted. If the Plaintiff answered "No" to question 5 in Section VII and is not asserting a wage loss claim or a reduction in lost earning capacity, then the Plaintiff is not required to provide Defendants with IRS Form 4506/4506-T. Defendants reserve the right to request records referred to in section II(6)(b) from Plaintiffs that did not answer yes to question 5, and the parties agree to meet and confer on any such request. To the extent after a request is made for these records, Plaintiffs will not agree to

produce such records, Defendants reserve the right to raise this issue with the Court.

c. **Authorizations for the Release of Employment Records**- If the Plaintiff answers "Yes" to question 5 in Section VII in the PFS and is asserting a claim for lost wages or a reduction in lost earning capacity, then the Plaintiff shall provide Defendants with a completed and signed *Employment Authorization* attached to the PFS as Exhibit "C" for each employer within the last five (5) years identified in the answer to question 5 in Section VII. If the Plaintiffs answered "No" to question 5 of Section VII and is not making a claim for lost wages or lost earning capacity then the Plaintiff is not required to provide Defendants with *Employment Authorizations*. Defendants reserve the right to request records referred to in Section II(6)(c) from Plaintiffs that did not answer yes to question 5, and the parties agree to meet and confer on any such request. To the extent after a request is made for these records, Plaintiffs will not agree to produce such records, Defendants reserve the right to raise this issue with the Court.

d. **Authorization for Release of Workers' Compensation Records**– If the Plaintiff answered "Yes" to question 19 in Section II of the PFS, stating that he/she applied for workers' compensation within the past seven (7) years, then the Plaintiff must provide a completed and signed (but undated) *Authorization for Release of Workers' Compensation Records* for each agency or company that Plaintiff submitted an application in the last 7 years in the form attached to the PFS as Exhibit "D". If the Plaintiff answered "No" to question 19 in Section II of the PFS, then she is not required to provide Defendants with a *Release of Workers' Compensation Records.*

e) **Authorization for Release of Disability Records**– If the Plaintiff answered "Yes" to question 19 in Section II of the PFS (stating that he/she applied for disability within the past seven (7) years, then the Plaintiff shall provide a completed and signed

(but undated) Authorization for Release for each agency or company you submitted your application to in the last 7 years in the form attached to the PFS as Exhibit "E."

f) **Authorization for Release of Educational Records**- For the educational institution that Plaintiff attended listed in response to question 14 in the PFS, Plaintiff shall provide a completed and signed (but undated) *Authorization for Release of Educational Records* in the form attached to the PFS as Exhibit "F." Defendants reserve the right to request records referred to in Section II(6)(f) from Plaintiffs and the parties agree to meet and confer on any such request. To the extent after a request is made for these records, Plaintiffs will not agree to produce such records, Defendants reserve the right to raise this issue with the Court.

g) **Insurance Records Authorizations**- For each company listed in the Plaintiffs answer to question 18 Section II of the PFS, the Plaintiff shall provide a completed and signed (but undated) *Authorization for Release of Insurance Records* in the form attached to the PFS as Exhibit "G."

h) **Authorization for Release of Psychotherapy Records**- If the Plaintiff answers "Yes" to question VII(3) in the PFS (stating that he/she was treated for a psychological/mental/emotional condition prior to the use of the Tylenol/acetaminophen products at issue in the lawsuit), then the Plaintiff shall provide a completed and signed (but undated) Authorization for Release of Psychotherapy records in the form attached to the PFS as Exhibit "H." Defendants reserve the right to request records referred to in Section II(6)(h) from Plaintiffs that did not answer yes to question VII(3), and the parties agree to meet and confer on any such request. To the extent after a request is made for these records, Plaintiffs will not agree to produce such records, Defendants reserve the right to raise this issue with the Court.

i. Defendants' Medical Record Service shall promptly notify all

Parties (Defendants and the individual Plaintiff's counsel) *via* E-mail upon receipt of the records collected pursuant to an authorization for psychotherapy records (Exhibit H) but shall not release the records retrieved pursuant to an authorization for psychotherapy records (Exhibit H) to Defendants for **five (5) business days** so that Plaintiffs shall have an opportunity to review the records and to make an application to the Court for a *Protective Order* if necessary (hereinafter "5-Day Review Period").

ii. In the event that Defendants' Medical Record Service delays production of the records to Plaintiffs, the 5-Day Review Period shall be extended by an equal number of days attributable to the delay.

iii. If Plaintiffs fail to make an application for a *Protective Order* on or before the end of the 5-Day Review Period, the Defendants' Medical Record Service is authorized to release the retrieved records to Defendants.

iv. If, prior to the end of the 5-Day Review Period, after reviewing the records retrieved by Defendants' Medical Record Service, Plaintiffs decide that they will not seek a *Protective Order* for the retrieved records, Plaintiffs shall notify Defendants' Medical Record Service *E-mail* that the records may be released to Defendants.

v. Plaintiffs shall make their best effort to review said retrieved records and notify if there is no objection to release before the end of the 5- Day Review Period.

vi. Nothing in section is intended to or meant to prohibit Plaintiffs from making an application for a *Protective Order* at any other time.

vii. Defendants shall be permitted, however, to have copies of medical records obtained by Defendants' Medical Record Service forwarded within the 5-Day

Review Period to Defendants' Global Pharmacovigilance department(s) for receiving, processing and accessing records in connection with adverse event and drug safety reporting requirements.

7. In addition to the various forms of *Authorization*s described above, Plaintiffs' counsel shall also maintain in their file unaddressed, executed *Authorizations.* Plaintiff's counsel shall provide executed *Authorizations* to Defendants' counsel within **14 days** of a request for *Authorizations*.

8. Defendants may not use *Authorizations* except in accordance with this Order. The Parties may subpoena records from any third-party pursuant to the Federal Rules of Civil Procedure or, in the case of out-of-state records, pursuant to other applicable law or rules. Any Party serving a Subpoena on a third-party shall provide the opposing Party a copy of the Subpoena when it is issue.

9. Undated Authorizations constitute permission for Defendants to date (and where applicable, re-date) Authorizations before sending to records custodians.

10. Defendants and Defendants' Medical Record Service shall not disclose to any employment, education, disability, worker's compensation, or insurance record-provider anything about the nature of any claim in this litigation, the nature of the Plaintiffs' claim or that the records being sought are for the purpose of litigation.

11. In the event an institution, agency or medical provider to which a signed authorization is presented refuses to provide responsive records, the individual Plaintiff's attorney and Defendants' counsel shall meet-and-confer to determine the most efficient way to resolve the issue such that the necessary records are promptly provided.

IV. DEFENDANT FACT SHEET ("DFS")

The Parties shall meet and confer on whether a Defendant Fact Sheet (DFS) is

appropriate in this MDL and if appropriate, present to the Court a proposed implementing Case Management Order.

SO ORDERED this 20th day of June, 2013

LAWRENCE F. STENGEL, J.

EXHIBIT "A"

EXHIBIT "A" TO CMO-10

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

IN RE: TYLENOL (ACETAMINOPHEN) MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION:	§	**MDL NO. 2436**
	§	**2:13-md-02436**
	§	**HON. LAWRENCE F. STENGEL**
	§	
	§	
THIS DOCUMENT RELATES TO PLAINTIFF:	§	
	§	

PLAINTIFF FACT SHEET

Each Plaintiff must complete this Plaintiff Fact Sheet ("PFS") and identify or provide documents and/or data responsive to the questions set forth below to the best of Plaintiff's knowledge. In completing this PFS, 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. If you cannot recall any information "I cannot recall" or a similar response is acceptable. Also, pursuant to Fed. R. 26(e)(2) "A party is under a duty seasonably to amend a prior response to an interrogatory, request for production, or request for admission if the party learns that the response is in some material respect incomplete or incorrect and if the additional or corrective information has not otherwise been made known to the other parties during the discovery process or in writing." What this means is that each Plaintiff has certain obligations relating to updating the information provided herein. This PFS shall be completed in accordance with the time period set forth in Case Management Order No.10.

In completing this form, please use the following definitions:

"You" and/or "Your" refers to the person whose alleged ingestion of the Tylenol/acetaminophen product at issue resulted in injury. In cases where Plaintiff alleges death secondary to Tylenol/acetaminophen ingestion, "You" and/or "Your" may also refer to the person(s) who seeks recovery on behalf of Plaintiff's decedent.

"Document" includes any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, through electronic devices into a reasonably useable form.

"Health Care Provider" means any doctor, physician, physician's assistant, surgeon, osteopathy, psychiatrist, psychologist, chiropractor, therapist, nurse, nurse practitioner, medical technician, medical assistant, healer, counselor, pharmacist, emergency medical personnel, or any other person who has been involved in the treatment of the person who claims injury from Tylenol/acetaminophen in this lawsuit.

"Tylenol" refers to the Tylenol branded product(s), including, but not limited to, Tylenol, Extra Strength Tylenol, Tylenol PM, Arthritis Strength Tylenol, Children's Tylenol, Infant's Tylenol, Tylenol Cold, Tylenol Sinus and/or any other over-the-counter form of Tylenol branded product.
"Acetaminophen" or "Acetaminophen-containing products" refers to prescription or over-the-counter generic or branded products which includes the drug acetaminophen as one or more of the active ingredients.

Sometimes a prescription drug containing acetaminophen may include the letters "APAP" to indicate that acetaminophen is an ingredient, such as, hydrocodone-APAP.

In the event the PFS does not provide you with enough space to complete your responses or answers, please attach additional sheets if necessary.

These responses are confidential and subject to the provisions of Case Management Order ("CMO") No. 1 (Protective Order) entered by the Court and CMO No. 10 governing Plaintiff Fact Sheets.

I. CASE INFORMATION

This PFS pertains to the following case:

Case caption:_____

Civil Action No._____

Name(s) of person(s) completing this form and relationship to the person who used the Tylenol®/acetaminophen product(s) at issue:

First Name:_____ Middle:_____ Last:_____ Suffix: _____

Address:_____ City:_____ State:_____ Zip:_____

Relationship to injured party:_____

II. PERSONAL INFORMATION ABOUT PERSON WHO CLAIMS INJURY FROM TYLENOL®/ACETAMINOPHEN

1. First Name:_____ Middle:_____ Last:_____ Suffix: _____

2. Address:_____ City:_____ State:_____ Zip:_____

3. Date you began living at this address:_____

4. Other than your current address, identify each address at which you have resided during the last fifteen (15) years and the dates you resided at each such address.

Address, City, State and Zip Code	Dates of Residence

5. Social Security Number:_____

6. Date of Birth: _____

7. Place of Birth: _____

8. Current Marital Status: _____

9. Maiden name and/or alternative names used _____

10. If married, name and occupation of current spouse:

First Name:_____ Middle:_____ Last:_____ Suffix: _____

Occupation: _____

11. For any marriages that ended within the past five (5) years, please provide the name(s) of each former spouse, the date(s) of marriage(s), the date(s) the marriage(s) ended and the nature of termination (i.e. death or divorce).

Spouse Name	Begin Date	End Date	Nature of the Termination

12. Has anyone filed a loss of consortium claim in connection with this lawsuit?

Yes ☐ No ☐

If "Yes," please identify the name, address and your relationship to each person with a loss of consortium claim:

_____

_____

13. If you have children, please identify each child's name, address and age.

_____

Child's Name	Address	Age

14. Please state your highest level of education, including the name of the institution you attended and the degree you obtained:

_____

_____

15. For the seven (7) year period prior to the date you first took the Tylenol®/acetaminophen product that you allege caused your injury, please identify each of your employers, the position you held, and the dates of employment with each employer.

Name of Employer	Position(s) Held	Dates of Employment

16. If you left any employment for a medical reason, please describe the medical condition:

_____

_____

17. Have you ever served in any branch of the military?

Yes ☐ No ☐

Branch and dates of service:_____

If "Yes," were you ever discharged or rejected from any type of military service for any reason relating to your medical, physical or psychiatric condition?

Yes ☐ No ☐

If "Yes," please explain:_____

18. Identify each insurance carrier with whom you had health insurance coverage at any time beginning seven (7) years prior to using the Tylenol®/acetaminophen product that you alleged caused your injury up to the present, and please include all private insurance and public assistance if applicable:

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

19. Have you applied for workers' compensation, social security disability benefits, private disability benefits, or state or federal disability benefits within the seven (7) year period prior to the date of your completion of this Plaintiff Fact Sheet?

Yes ☐ No ☐ I do not know ☐

If "Yes," separately state for each application:

a. Name of agency and date of application:_____

b. Nature of claimed injury/disability: _____

20. Have you ever been denied life insurance for any reason related to your health?

Yes ☐ No ☐ I do not know ☐

If "Yes," please state the date of the denial, name of the life insurance company and the reason for the denial, if known:

_____

21. Have you ever filed a lawsuit other than the present suit relating to any bodily injury within the past ten (10) years?

Yes ☐ No ☐ I do not recall ☐

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

_____

_____

22. In the last 10 years, have you filed for bankruptcy?

Yes ☐ No ☐

If "Yes," please identify:

(a) The Court(s) which you filed the Petition(s): _____

(b) Case/Claim Number(s): _____

(c) Date Filed: _____

(d) Resolution of each case: _____

23. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to any crime that involved an act of dishonesty or providing a false statement?

Yes ☐ No ☐

If "Yes," please complete the following:

a) Charge to which you plead guilty or were convicted of: _____

b) Court where action is or was pending: _____

III. HEALTH CARE PROVIDERS AND PHARMACIES (please attach extra pages as necessary to answer this section completely.)

1. Identify each doctor or other health care provider who you have seen for medical care and treatment within ten (10) years prior to the Tylenol®/acetaminophen use that you alleged caused your injury.

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

2. Identify each hospital, clinic, or health care facility where you were treated or hospitalized (inpatient, out-patient, or emergency room visit) within ten (10) years prior to your use of the Tylenol®/acetaminophen product that you alleged caused your injury.

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

3. Identify each pharmacy from which you had prescription medications dispensed within ten (10) years prior to your use of the Tylenol®/acetaminophen product that you alleged caused your injury.

Name	Address	Date(s) of use of pharmacy (if known)

IV. MEDICAL BACKGROUND

1. Age, Height and Weight at the Time of Your Claimed Injury:

   Age:_____ Height: _____ Weight:_____

2. Current Age, Height and Weight:

   Age:_____ Height: _____ Weight:_____

3. Alcohol Consumption:

   a) For the two year year period prior to your use of Tylenol®/acetaminophen up to the present, have you consumed alcohol (beer, wine, etc.)?

      Yes ☐ No ☐

      If "Yes," state your approximate average alcohol consumption:

      ____ drinks per week; or,

      ____ drinks per month; or,

      ____ drinks per year

If other, describe:

_____

_____

   b) Have your alcohol consumption patterns changed in the past ten (10) years?

      Yes ☐ No ☐ I do not recall ☐

      If Yes, please explain:

_____

_____

_____

c) During the ten (10) day period prior to your injury in this case, if you were ingesting Tylenol/acetaminophen during that time period, state whether you also were consuming alcohol during those days that you were ingesting Tylenol/acetaminophen.

Yes ☐ No ☐ I do not recall ☐

If "Yes", identify all alcohol consumed, by date, amount consumed and type of alcohol consumed (i.e., beer, wine, spirits) that you consumed while also ingesting Tylenol/acetaminophen.

_____

_____

_____

4. Have you ever attended any type of group, meeting or class related to alcohol and/or drug use or abuse and/or sought to prevent your own alcohol and/or drug use or abuse?

Yes ☐ No ☐ I do not recall ☐

If "Yes," state each such meeting date, the name and address of the sponsoring group (e.g., Alcoholics Anonymous).

_____

_____

5. During the ten (10) day period immediately prior to your injury in this case, was there a period of time that you did not eat or had very limited food intake?

Yes ☐ No ☐ I do not know ☐

If "Yes," please state on which day(s) during the ten (10) day period that you did not eat or had very limited food intake and the reason(s) why you did not eat or consumed very little food intake.

_____

_____

6(a). Prior to the use of the Tylenol®/acetaminophen product(s) that you allege caused your injury , were you ever diagnosed with or treated for any of the following conditions? Please select "Yes", "No" or "Unknown" for each condition.

Condition	Yes	No	Unknown/Not Sure
Alcoholism			
Anemia			
Diabetes			
Eating Disorder (e.g., Anorexia, Bulimia)			
Hepatitis			
Herpes Simplex Virus			
Human Immunodeficiency Virus (HIV)			
Liver Failure			
Liver Disorders/Liver Disease			
Lupus			
Malnutrition			
Psychological/Mental/Emotional Condition			
Depression			
Suicide Ideation/Attempted Suicide			
Wilson's Disease			

6(b). For each condition for which you answered "Yes," please provide the information requested below (and attach additional pages as necessary):

Condition	Approximate Date of Onset	Name and Address of Treating Health Care Provider or Health Care Facility

V. OTHER MEDICATION USE

1. Are there any prescription medications that you have taken in the two (2) year period before the injuries claimed in this lawsuit?

   Yes ☐ No ☐ I do not know or cannot recall ☐

   If "Yes," please identify:

Name of Prescription Medication	The health care provider(s) who Prescribed the Medication	Approximate dates/years taken	Reason(s) for Use

2. For the two-year period before the onset of injuries for which recovery is sought in this action, please identify: (a) the name of each and every over-the-counter and prescription acetaminophen-containing drug product(s) ingested or otherwise used by you; (b) the prescribing physician, if any; (c) the pharmacy and/or retail location where the product was purchased, (d) the reason(s) for use; (e) the duration of use and (f) indicate whether it was used in the 30 day period before the onset of injuries for which recovery is sought.

Name of over-the- counter or prescription drug containing acetaminophen:	Prescribing health care provider (if any):	Pharmacy or retail location where purchased:	Reason(s) for use	Duration of Use (starting and ending dates)	Used in the 30 day period before the onset of injuries for which recovery is sought.

3. Please identify: (a) the name of each and every over-the-counter and prescription acetaminophen-containing drug product(s) ingested or otherwise used by you following the onset of injuries for which recovery is sought in this lawsuit from the date of onset of injuries to the present; (b) the prescribing physician, if any; (c) the pharmacy and/or retail location where the product was purchased; (d) the reason(s) for use; (e) the dose and frequency of use; and (f) the duration of use

Name of over-the- counter or prescription drug containing acetaminophen:	Prescribing health care provider (if any):	Pharmacy or retail location where purchased:	Reason(s) for use	Dose and Frequency of Use	Duration of Use (starting and ending dates)

VI. TYLENOL®/ACETAMINOPHEN USE

TO THE EXTENT THAT YOUR ANSWERS TO THE QUESTIONS IN THIS SECTION ARE SET FORTH IN THE PRECEDING SECTION YOU MAY REFER TO YOUR ANSWERS IN THE PRECEDING QUESTION ABOVE.

1. Identify each Tylenol®/acetaminophen product(s) that you claim caused the injury at issue in this lawsuit:

   _____

2. Identify the formulation of each Tylenol®/acetaminophen product(s) at issue (i.e. Regular Strength, Extra Strength, Caplets, Tablets, Gel Caps, Liquid, Flavor etc.):

   _____

3. Identify the date(s) of use of each Tylenol®/acetaminophen product(s) at issue:

   _____

4. Identify the medical condition(s), symptoms and/or reasons you ingested the Tylenol®/acetaminophen product(s) at issue. Please include the dosage ingested, frequency of use and total amount ingested for each such Tylenol®/acetaminophen product at issue.

Medical Condition/ Reason for Use	Dosage Ingested	Dates of Use	Frequency of Use	Total Ingested

5. Identify every individual present when you ingested each such Tylenol®/acetaminophen product at issue.

Dates of Ingestion	Individual(s) Present

6. Provide in the chart below the name(s) and address(es) of the health care provider(s) who prescribed or recommended Tylenol®/acetaminophen

Name of health care provider(s)	Address of health care provider(s)

7. Provide in the chart below the name(s) and address(es) of the pharmacy(ies) or other store(s) or location(s) from which you obtained the Tylenol®/acetaminophen product(s) at issue

Name of Pharmacy or Other Store/Location	Address, Including City, State and ZIP Code

8. Do you have in your possession or does your attorney have the bottle, box and/or packaging of the Tylenol®/acetaminophen product(s) at issue?

Yes ☐ No ☐

If "Yes," please identify who has custody of the bottle, box and/or packaging information and specify the items in custody:

_____

If "No," explain why you do not have the bottle, box and/or packing:

_____

9. Has any health care provider or person (other than your attorney and other than non-treater experts that you or your attorney has consulted with or retained on your behalf) made a statement, orally or in writing, that the Tylenol®/acetaminophen product(s) at issue caused your injury?

Yes ☐ No ☐ I cannot recall ☐

If "Yes," please identify:

Name	Statement(s)	Oral or Written	Date and Place of Statement(s)	Person(s) Present during Statement(s)

10. Has any health care provider or person (other than your attorney and other than non-treater experts that you or your attorney has consulted with or retained on your behalf) made a statement, orally or in writing, that your ingestion of Tylenol®/acetaminophen product(s) at 4 grams of acetaminophen or less per day caused your injury?

Yes ☐ No ☐ I do not know or cannot recall ☐

If "Yes," please identify:

Name	Statement(s)	Oral or Written	Date and Place of Statement(s)	Person(s) Present during Statement(s)

11. Have you ever seen or heard any advertisements (e.g., in magazines, newspaper, coupons, or television, radio commercials) for Tylenol®/acetaminophen?

Yes ☐ No ☐ I do not know or cannot recall ☐

(a) If "Yes," please identify where you saw or heard the advertisement(s), the date(s) you saw or heard the advertisement(s), and the content of the advertisement. If you cannot remember the exact date, provide your best recollection.

_____

_____

(b) If in a magazine(s) or newspaper, or coupon do you or your attorney have a copy of the advertisement(s)?

Yes ☐ No ☐

If "Yes," please identify who has custody of each such advertisement: _____

12. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives regarding any factual or legal issue in this lawsuit?

Yes ☐ No ☐ I do not know or cannot recall ☐

If "Yes," set forth the date of the communication, the method of communication, the name of the representative with whom you communicated and the substance of the communication between you and any representative(s) of the Defendants: _____

_____

VII. INJURIES & DAMAGES

1. Please describe the nature of the physical injuries for which you are seeking compensation in this lawsuit:

_____

_____

_____

2(a). If you were taken to a doctor or health care facility (e.g., hospital or clinic) to be treated for the injury(ies), state the name and address (if known) of the persons, police department, fire department, emergency medical workers, or ambulance company who took you to the doctor or health care facility:

_____

_____

2(b). Were you treated by any health care provider or at any hospital for this/these injury(ies)?

Yes ☐ No ☐

If "Yes," please provide the following information:

Approximate date(s)	Health care provider	Hospital and address

2(c). Are you currently being treated by any health care provider for these injuries?

Yes ☐ No ☐

If "Yes," please provide the following information:

Approximate date(s) treatment	Health care provider	Hospital and address

3. Do you claim that your use of Tylenol®/acetaminophen caused or aggravated any psychiatric and/or psychological condition(s) for which damages are being sought in this lawsuit?

Yes ☐ No ☐

If "Yes," please state the following as it pertains to your treatment of any psychiatric and/or psychological condition(s) in the last seven (7) years or since the onset of the injury that you believe was caused by Tylenol/acetaminophen, whichever is longer:

Name of psychiatrist, psychologist or other mental health care provider	Address and Telephone	Reason for Treatment	Approx. Dates/Years of Treatment/ Visits

4. Are you claiming any out of pocket expenses as a result of your use of Tylenol®/acetaminophen?

Yes ☐ No ☐

If "Yes," please itemize those expenses and provide the amount of each such expense:

_____

_____

_____

5. Are you asserting a claim for lost wages or lost earning capacity?

Yes ☐ No ☐

If "Yes," please provide the address for each employer identified above and state the following for the last five (5) years:

Name of Employer	Employer Address, City, ST, Zip	Year	Annual Gross Income

VIII. FACT WITNESSES

1. Other than your health care providers (or the person's you identified in VI question 5 above), please identify all persons whom you believe possess information concerning the use of the Tylenol/acetaminophen product at issue, your injury(ies) and current medical condition. Please state each person's name, address and relationship to you (attach additional pages as necessary):

Name	Address	Relationship to You

2. If there are any individuals who witnessed your injury as it occurred who are not listed above, please identify any such person below by name, address and relationship to you.

Name: _____

Address: _____ City: _____ State:_____ Zip: _____

Relationship to you: _____

IX. ELECTRONICALLY STORED INFORMATION

1. Do you have a computer?

   Yes ☐ No ☐

2. If so, are you a member of MySpace, Facebook, Instagram, LinkedIn, Twitter or other social media websites?

   Yes ☐ No ☐

3. Please identify any websites that you owned, maintained, used for social networking, instant messaging, tweeting, blogging or otherwise posting messages on-line to include, but not limited to, MySpace, Facebook, Instagram and/or Twitter on which you have posted anything in regard to Tylenol/acetaminophen and/or this lawsuit since the onset of the injuries at issue in this lawsuit. Please provide the name or identity used by you in connection with any such website, posting or social network site.

   _____

   _____

   _____

X. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under oath and do hereby swear and affirm that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry.

_____

Signature of Plaintiff

_____

Date

XI. DOCUMENT DEMANDS

All of the document requests below exclude the production of any documents concerning the discovery and investigation that is subject to the attorney-client or other privilege or the work-product doctrine. To the extent the responsive documents are in your possession, custody or control, attach a copy of each of the documents to this Plaintiff Fact Sheet. Plaintiffs shall be permitted to supplement their document production with documents that may not be in their personal possession at the time of the service of this Plaintiff Fact Sheet, and to supplement their production of documents in the event additional documents that are encompassed within this Document Demand are learned about or discovered by Plaintiff subsequent to the service of this Plaintiff Fact Sheet.

A. Relevant Documents

Please indicate whether you have any of the following Documents in your custody or possession and, if so, attach a copy of each Document to this PFS:

1. A copy of all medical records and/or documents relating to the use of Tylenol/acetaminophen from any hospital or health care provider who treated you in the past 10 years and who treated you for any disease, condition or symptom referred to in any of your responses to the questions above and concerning any condition you claim is related to the use of Tylenol/acetaminophen including, but not limited to, all imaging studies of any part of your body that relate in any manner to the diagnosis, treatment, care or management of your condition and the injuries alleged in this lawsuit.

   ☐Attached
   ☐I have no documents
   ☐Not applicable

2. If you have been the claimant or subject of any workers' compensation, social security or other disability proceeding, all documents relating to such proceeding.

   ☐Attached
   ☐I have no documents
   ☐Not applicable

3. All documents constituting, concerning or relating to the Tylenol/acetaminophen product that you alleged caused your injury to include the label, product use instructions, product warnings, package inserts or other materials distributed with or provided to you in connection with your use of Tylenol/acetaminophen.

☐Attached
☐I have no documents
☐Not applicable

4. Copies of advertisements or promotions for Tylenol/acetaminophen and articles discussing Tylenol/acetaminophen.

☐Attached
☐I have no documents
☐Not applicable

5. Copies of the entire packaging, including the box and label for the Tylenol/acetaminophen product that you alleged caused your injury.

☐Attached
☐I have no documents
☐Not applicable

6. All documents relating to your purchase of Tylenol/acetaminophen including, but not limited to, receipts, containers, labels, or records of purchase.

☐Attached
☐I have no documents
☐Not applicable

7. All documents known to you and in your possession which mention Tylenol/acetaminophen or any alleged health risks or hazards related to Tylenol/acetaminophen in your possession at or before the time of the injury alleged in this lawsuit, other than legal documents, documents provided by your attorney or documents obtained or created for the purpose of seeking legal advice or assistance.

☐Attached
☐I have no documents
☐Not applicable

8. All documents in your possession or anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants.

☐Attached
☐I have no documents
☐Not applicable

9. All documents constituting any communications or correspondence between you and any representative of the Defendants.

☐Attached
☐I have no documents
☐Not applicable

10. All photographs, drawing, journals, slides, videos, DVDs or any other media, including any "day in the life" videos, photographs, recordings or other media that you may utilize to demonstrate damages or relating to your alleged injury.

☐Attached
☐I have no documents
☐Not applicable

11. Copies of all documents you (and not your lawyer) obtained from any source related to Tylenol/acetaminophen or to the alleged effects of using Tylenol/acetaminophen.

☐Attached
☐I have no documents
☐Not applicable

12. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care providers.

☐Attached
☐I have no documents
☐Not applicable

13. Copies of any writings comprising or relating to any statements made by you or anyone else (other than your attorneys) relating to this litigation in your possession.

☐Attached
☐I have no documents
☐Not applicable

14. Copies of any documents concerning the discovery and investigation of plaintiff's decedent's death, if applicable, to include ambulance records, police reports, coroner's reports, reports of emergency medical technicians or other medical personnel, 911 call transcripts and public or private investigative reports.

☐Attached
☐I have no documents
☐Not applicable

15. Copies of any communications concerning plaintiff's decedent's death, if applicable, received from or sent to any person to include any documents or websites concerning any memorial service or remembrance held for the decedent.

☐Attached
☐I have no documents
☐Not applicable

B. <u>Authorizations</u>

Please execute the authorizations which have been provided to Plaintiff and attach a signed copy of the authorization to the finalized PFS.

Exhibit A

AUTHORIZATION AND CONSENT
TO RELEASE RECORDS AND PROTECTED HEALTH INFORMATION
(Excluding psychotherapy notes)

Name of Individual:

Social Security Number:

Date of Birth:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

Open Records, Administrative Specialist, Department of Workers' Claims

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to **The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040**, and its authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results, genetic testing information, and alcohol and drug abuse treatment) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic, hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

Records should be sent for the past ten (10) years.

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

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

The above list of types of records and other information to be disclosed is intended to be illustrative and not exhaustive. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter:

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice either to **The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040** and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to **The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040** pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ _____, and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for drug or alcohol abuse,

Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, Sickle Cell Anemia, Tuberculosis and Genetic testing and counseling.

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of_____, or (ii) five (5) years after the date of signature of the undersigned below.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to <u>The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040</u> and its authorized representatives, by any entities included in the categories listed above.

Date: _____ _____

Signature of Individual or Individual's Representative

Individual's Name and Address: _____

Printed Name of Individual's Representative (If applicable)

_____ _____

Relationship of Representative to Individual (If applicable)

_____

_____

Description of Representative's authority to act for Individual (If applicable)

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

Exhibit B

Form **4506**

(Rev. January 2011)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

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 original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

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

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

4 Previous address shown on the last return filed if different from line 3 (See instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Caution. *If the tax return is being mailed to a third party, ensure that you have filled in line 6 and line 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

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. **Note.** *For tax returns being sent to a third party, this form must be received within 120 days of signature date.*

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**	

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate a third party to receive the tax return. See line 5.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year and the chart below shows two different RAIVS teams, send your request to the team based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the "Internal Revenue Service" at:
Florida, Georgia (After June 30, 2011, send your transcript requests to Kansas City, MO)	RAIVS Team P.O. Box 47-421 Stop 91 Doraville, GA 30362
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888
Connscticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on Lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. Sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

Form **4506-T**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

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

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

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution. *If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ► _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2010, filed in 2011, will not be available from the IRS until 2012. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . ☐

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **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 four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. _____ _____ _____ _____

Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return . . . . . ☐

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information 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-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

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

Section references are to the Internal Revenue Code unless otherwise noted.

What's New

The IRS has created a page on IRS.gov for information about Form 4506-T at *www.irs.gov/form4506*. Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

General Instructions

CAUTION. *Do not sign this form unless all applicable lines have been completed.*

Purpose of form. Use Form 4506-T to request tax return information. You can also designate (on line 5) a third party to receive the information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note. If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to the "Internal Revenue Service" at:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888 559-456-5876
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 801-620-6922
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P. O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Products Coordinating Committee
SE:W:CAR:MP:T:M:S
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

Exhibit C

AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm of Butler Snow O'Mara Stevens & Cannada, PLLC, and/or to The Marker Group, Inc., any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records should be sent for the past five (5) years. This authorization should also be construed to permit agents or designees of Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc. to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. Copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

Unless revoked in writing, this authorization shall expire one year after it is signed. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Alyson Jones, Esq. c/o Butler Snow O'Mara Stevens & Cannada, PLLC; PO Box 6010, Ridgeland, MS 39158 and/or The Marker Group, Inc.; 13105 Northwest Freeway, Suite 300, Houston, TX 77040, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the Individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Butler Snow O'Mara Stevens & Cannada, PLLC and/or to The Marker Group, Inc.

Name of Employee	Signature of Employee or Employee Representative
Former/Alias/Maiden Name of Employee	Date
Employee's Date of Birth	Name of Employee Representative
Employee's Social Security Number	Description of Authority
Employee's Address	

Exhibit D

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm of Butler Snow O'Mara Stevens & Cannada, PLLC, and/or to The Marker Group, Inc., any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records should be sent for the past seven (7) years. This authorization should also be construed to permit agents or designees of Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc. to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

Unless revoked in writing, this authorization shall be expire one year after it is signed. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Alyson Jones, Esq. c/o Butler Snow O'Mara Stevens & Cannada, PLLC; PO Box 6010, Ridgeland, MS 39158 and/or The Marker Group, Inc.; 13105 Northwest Freeway, Suite 300, Houston, TX 77040, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Butler Snow O'Mara Stevens & Cannada, PLLC and/or to The Marker Group, Inc.

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

Exhibit E

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778). ***You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

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 selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) _____

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Exhibit F

AUTHORIZATION TO DISCLOSE EDUCATIONAL INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm or Butler Snow O'Mara Stevens & Cannada, PLLC, and/or to The Marker Group, Inc., any and all records containing educational information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc. to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

> all school records including application and admission paperwork, attendance records, transcripts, diplomas, health and physical examination records, immunization records, nurses notes, disciplinary records, correspondence and any and all other information and records pertaining to the above-named individual. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

Unless revoked in writing, this authorization shall expire one year after it is signed. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Alyson Jones, Esq. c/o Butler Snow O'Mara Stevens & Cannada, PLLC; PO Box 6010, Ridgeland, MS 39158 and/or The Marker Group, Inc.; 13105 Northwest Freeway, Suite 300, Houston, TX 77040, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Butler Snow O'Mara Stevens & Cannada, PLLC and/or to The Marker Group, Inc.

Name of Student	Signature of Student or Student Representative
Former/Alias/Maiden Name of Student	Date
Student's Date of Birth	Name of Student Representative
Student's Social Security Number	Description of Authority
Student's Address	

Exhibit G

AUTHORIZATION TO DISCLOSE INSURANCE INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm of Butler Snow O'Mara Stevens & Cannada, PLLC, and/or to The Marker Group, Inc., any and all records containing insurance information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records should be sent for the past seven (7) years. This authorization should also be construed to permit agents or designees of Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc. to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

Unless revoked in writing, this authorization shall expire one year after it is signed. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Alyson Jones, Esq. c/o Butler Snow O'Mara Stevens & Cannada, PLLC; PO Box 6010, Ridgeland, MS 39158 and/or The Marker Group, Inc.; 13105 Northwest Freeway, Suite 300, Houston, TX 77040, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Butler Snow O'Mara Stevens & Cannada, PLLC and/or to The Marker Group, Inc.

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

Exhibit H

AUTHORIZATION TO DISCLOSE PSYCHIATRIC RECORDS AND PSYCHOTHERAPY NOTES INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm of Butler Snow O'Mara Stevens & Cannada, PLLC, and/or to The Marker Group, Inc., any and all psychiatric records and psychotherapy notes records, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records should be sent for the past ten (10) years.This authorization should also be construed to permit agents or designees of Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc. to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

> complete copies of all psychiatric records and psychotherapy notes reports, therapist's notes, social worker's records, all medical records, physicians' records, surgeons' records, pathology/cytology reports, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, records of drug abuse and alcohol abuse, physicals and histories, nurses' notes, correspondence, insurance records, consent for treatment, statements of account, itemized bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning the physical or mental condition of this patient, or documents containing information regarding amendment of protected health information (PHI) in the medical records. Copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

Unless revoked in writing, this authorization shall expire one year after it is signed. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Alyson Jones, Esq. c/o Butler Snow O'Mara Stevens & Cannada, PLLC; PO Box 6010, Ridgeland, MS 39158 and/or The Marker Group, Inc.; 13105 Northwest Freeway, Suite 300, Houston, TX 77040 except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization expressly authorizes the above-named entity to disclose psychiatric records and psychotherapy notes and information to Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc., and authorizes re-disclosure of said records and information to consultants, experts, agents, and/or other counsel in this litigation.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**

I have read this Authorization and understand that it will permit the entity identified above to disclose my PHI, including psychiatric records and psychotherapy notes records and information, to Butler Snow O'Mara Stevens & Cannada, PLLC and/or to The Marker Group, Inc. I further understand that records pertaining to psychiatric records and psychotherapy notes information may be specifically protected by federal and/or state regulations; by signing this authorization I am allowing the disclosure of any psychiatric records and psychotherapy notes information held by the entity identified above.

Name of Patient	Signature of Patient or Patient Representative
Former/Alias/Maiden Name of Patient	Date
Patient's Date of Birth	Name of Patient Representative
Patient's Social Security Number	Description of Authority
Patient's Address	

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm of Butler Snow O'Mara Stevens & Cannada, PLLC, and/or to The Marker Group, Inc., any and all psychiatric records and psychotherapy notes, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records should be sent for the past ten (10) years.This authorization should also be construed to permit agents or designees of Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc. to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

> complete copies of all psychiatric records and psychotherapy notes as defined by HIPAA 45 C.F.R. 164.501: psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

Unless revoked in writing, this authorization shall expire one year after it is signed. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Alyson Jones, Esq. c/o Butler Snow O'Mara Stevens & Cannada, PLLC; PO Box 6010, Ridgeland, MS 39158 and/or The Marker Group, Inc.; 13105 Northwest Freeway, Suite 300, Houston, TX 77040 except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization expressly authorizes the above-named entity to disclose psychiatric records and psychotherapy notes and information to Butler Snow O'Mara Stevens & Cannada, PLLC and/or The Marker Group, Inc., and authorizes re-disclosure of said records and information to consultants, experts, agents, and/or other counsel in this litigation.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**

I have read this Authorization and understand that it will permit the entity identified above to disclose my PHI, including psychiatric records and psychotherapy notes, to Butler Snow O'Mara Stevens & Cannada, PLLC and/or to The Marker Group, Inc. I further understand that records pertaining to the psychiatric records and psychotherapy notes may be specifically protected by federal and/or state regulations; by signing this authorization I am allowing the disclosure of any psychiatric records and psychotherapy notes held by the entity identified above.

Name of Patient	Signature of Patient or Patient Representative
Former/Alias/Maiden Name of Patient	Date
Patient's Date of Birth	Name of Patient Representative
Patient's Social Security Number	Description of Authority
Patient's Address	