UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

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

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

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

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

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

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

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

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

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

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

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

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

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

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

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

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

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

_____
Name of Patient or Personal Representative

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

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

_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

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

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

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

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

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

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

- All psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

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

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

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

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

_____
Name of Representative

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

_____
Street Address

_____
City, State and Zip Code

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

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

_____
Signature of Patient or Personal Representative

_____
Dated

_____
Name of Patient or Personal Representative

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

_____
Witness Signature

_____
Dated

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

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

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

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

TO: _____
Name

_____
Address

_____
City, State and Zip Code

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

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

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

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

_____
Name of Employee

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

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

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

_____

Name of Representative

_____

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

_____

Street Address

_____

City, State and Zip Code

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to your records custodian. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this employment and unemployment information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my employment and unemployment information, I can contact the releaser indicate above.

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

_____ _____

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

_____ _____

Dated Dated

_____

Name of Patient or Personal Representative

_____

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

This authorization is valid only for records from _____

Name

ACKNOWLEDGEMENT

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

_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

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

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

TO: _____
Name

_____
Address

_____
City, State and Zip Code

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

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

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

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

_____
Name of Employee

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

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

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

_____

Name of Representative

_____

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

_____

Street Address

_____

City, State and Zip Code

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to your records custodian. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this employment and unemployment information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my employment and unemployment information, I can contact the releaser indicate above.

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

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

_____ _____

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

_____ _____

Dated Dated

_____

Name of Patient or Personal Representative

_____

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

This authorization is valid only for records from _____

Name

ACKNOWLEDGEMENT

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

_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

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

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

TO: _Social Security Disability_____

_____
Address
_____
City, State and Zip Code

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

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

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

- All Social Security Disability records.
- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

- All billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits.

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

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

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

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

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

_____
Name of Patient or Personal Representative

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

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

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

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

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

TO: _Social Security Disability_____

_____
Address

_____
City, State and Zip Code

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

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

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

- All Social Security Disability records.
- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

- All billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits.

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

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

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

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

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

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

Name of Patient or Personal Representative

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

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