SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY

CASE NO. 624
MASTER DOCKET NO.: BER-L-____ - _____
CIVIL ACTION

IN RE STRYKER LFIT CoCr V40 FEMORAL HEADS HIP IMPLANT LITIGATION

PLAINTIFF FACT SHEET

INDIVIDUALS REQUIRED TO COMPLETE THE PLAINTIFF FACT SHEET

Pursuant to the October __, 2017, Implementing Order entered in the above-captioned litigation, a completed Plaintiff Fact Sheet ("PFS") shall be provided for each individual plaintiff named in a complaint that has been filed or transferred into the *In re Stryker LFIT CoCr V40 Femoral Heads Hip Implant Litigation*, Case No. 624.

GENERAL INSTRUCTIONS

Definitions

The following definitions shall apply to this PFS:

The "Device" refers to the LFIT CoCr V40 Femoral Head.

"You" or "Your" refers to the person who had the Device(s) implanted.

"Document" means any writing or record of any type, however produced an whatever the medium on which it was produced, and includes, without limitation, the original and non-identical copy (whether different from the original because of handwritten notes or underlining on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meetings, calendars, diaries or journals, minutes of meetings, interoffice communications, electronic mail and other forms of electronic communication (including but not limited to postings on websites, blogs and/or social media), message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, X-rays, explants, devices, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings or pictures of any kind or description.

For Those Completing The PFS in Representative Capacity

If the individual completing this Plaintiff Fact Sheet is doing so in a representative capacity on behalf of someone who has died or who otherwise is physically or mentally unable to complete the PFS, the individual doing so must answer as completely as possible for that person.

Additional Space for Completeness

In filling out any section or sub-section of this form, additional sheets of paper should be used and submitted as necessary to provide complete and accurate information.

Accuracy and Supplementation

The individual completing this Plaintiff Fact Sheet is under oath and must provide information that is true and correct to the best of his or her knowledge, information and belief. If the response to any question is that the person completing this Plaintiff Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). In addition, if the person completing this Plaintiff Fact Sheet learns that any response is incomplete or incorrect at any time, or if the provided information changes, the person is obligated to supplement the pertinent response(s) to provide the corrected or additional information within 30 days of when he or she becomes aware of this information.

Non-Waiver of Additional Requests

This form requests information and documents about your background and medical condition for a specified period of time. However, Defendant reserves and does not waive the right to request additional information and information for a broader time period on a case by case basis.

I. CASE INFORMATION

1. Name of individual(s) who has/have filed a complaint or on whose behalf a complaint has been filed (first, middle name or initial, last):

_____

2. State the following for the civil action that you filed:

Case Caption: _____

Docket Number: _____

Court in which action was originally filed: _____

Name, address, telephone number, fax number and e-mail address of the attorney you retained and the principal attorney representing you in the civil action, if different:

Name: _____
Firm: _____
Address: _____
Telephone Number: _____
Fax Number: _____
E-mail Address: _____

3. If you are completing this Plaintiff Fact Sheet in a representative capacity for an individual who has filed a complaint or on whose behalf a complaint was filed (e.g., on behalf of the estate of a deceased person), please complete the following:

a. Your name: _____

b. Current Address: _____

c. In what capacity are you representing the individual or estate: _____

d. If you were appointed as a representative for the individual or the individual's estate, state the following:

Court which appointed you: _____
Date of Appointment: _____

e. What is your relationship to the individual or the estate: _____

f. If you represent a decedent's estate, please state the date and cause of decedent's death:

_____

INSTRUCTION: **THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS IMPLANTED WITH THE DEVICE(S) AT ISSUE.**

II. PERSONAL INFORMATION FOR IMPLANTED INDIVIDUAL

1. Name (first, middle name or initial, last): _____

2. Maiden or other names used and dates you used those names: _____

_____

3. Sex: Female _____ Male _____

4. Current address and date when you began living at this address: _____

_____

5. Identify each address at which you have resided for the period from ten (10) years before your first hip surgery up to the present, the dates you resided at each and with whom you resided:

Address	Dates of Residence	Others Residing With You at this Address

6. Social Security Number: _____

7. Date and place of birth: _____

8. Current marital/domestic partnership/civil union status: _____

9. If married or in a domestic partnership/civil union, please provide the following information:

   Date of marriage/domestic partnership/civil union: _____

   Name of spouse/partner: _____

   Date and place of birth of spouse/partner: _____

   Spouse's/partner's occupation: _____

10. If married or in a domestic partnership/civil union, has your spouse/partner filed a loss of consortium or other claim in this action?

    Yes _____ No _____

11. Name(s) of all former spouse(s)/partner(s), dates of marriage(s)/domestic partnership(s)/civil union(s) and dates the marriage(s)/domestic partnership(s)/civil union(s) were terminated, and the nature of the termination (i.e., death, divorce): _____

_____

_____

12. If you have children, list each child's name, date of birth and address: _____

_____

_____

13. Identify all schools you attended, starting with high school:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

14. Are you currently employed? Yes _____ No _____

If yes, please identify your current employer with name, address and telephone number, and state your position there: _____

_____

If not currently employed, when and where were you last employed and what was your last position? _____

_____

If not currently employed, why did your last employment end? _____

_____

15. For the period of time from ten (10) years before your first hip surgery, until the present, identify all of your employers, with name, address and telephone number, your employment dates, your position there, and your reason for leaving:

Name of Employer	Address and Telephone Number	Dates of Employment	Describe Your Position or Duties and Specify if Job Required Manual Labor	Reason for Leaving

16. For any previous or current employment involving occupational exposure to cobalt or heavy metals, identify the employer, dates of employment, nature of exposure and metal(s) exposed to, and dates of exposure: _____

_____

_____

17. Identify your Driver's License Number and the issuing state and/or provide a copy of your license (if you have had driver's licenses in more than one state, list separate responses for each state): _____

_____

18. For the period from five (5) years before your first hip surgery until the present, describe your average daily activities (e.g., household chores, grocery shopping, landscaping, travel, child care, etc.)

Type of Activity	Dates/Years Engaged in Activity	Approximate Number of Hours Per Week Spent on Activity

19. For the period from five (5) years before your first hip surgery until the present, please indicate if you have actively participated in any sports or exercise:

Yes _____ No _____

If yes, state the following:

Type of Sport/Exercise	Dates/Years Played	Approximate Number of Hours You Played Per Week	Approximate Number of Hours You Practiced/Exercised Per Week

Provide the name, address and dates of membership of any gyms or fitness clubs to which you currently belong or belonged in the five (5) years before your first hip surgery, or at which you attended fitness classes during the same period: _____

_____

_____

20. Set forth any and all email addresses, social media account usernames/handles, personal website addresses and/or blog addresses that you have maintained or used for the period from five (5) years before your first hip surgery until the present: _____

_____

_____

21. Have you ever served in any branch of the military? Yes _____ No _____

Branch and dates of service: _____

If you were ever discharged for any reason relating to your medical, physical, psychiatric or emotional condition(s), state what that condition was: _____

_____

_____

If you were ever denied enlistment into the military for any reason relating to your medical, physical, psychiatric or emotional condition(s), state the year in which you were denied enlistment and the condition for which you were denied enlistment: _____

_____

_____

22. Does any third party have decision making authority over the terms of any settlement or other resolution of your claim?

Yes _____ No _____

If Yes, identify the name and address of the third party and the basis for the third party's decision making authority over the terms of any settlement or resolution of your claim:

_____

_____

23. Has any portion of your potential recovery in this lawsuit been assigned or otherwise promised to any third-party (other than a contingency fee arrangement with your attorneys)?

Yes _____ No _____

If you answered "Yes," set forth the name and address of the third-party, the amount of any such recovery assigned or promised to the third-party, the consideration for such assignment or promise, and provide a copy of any written agreement or other documents evidencing the assignment or promise. _____

_____

_____

III. IMPLANT INFORMATION

1. Regarding the Device(s) at issue in this lawsuit, state:

   A. Implant Date(s): _____

   B. Identify the Device(s) at issue in this lawsuit that you received by the name, catalog number(s), and lot number(s): _____

   _____

   Side of Body (for implant at issue): Right ☐ Left ☐ Both ☐ (check one)

   C. Identify *any other hip replacement components or hardware* that you received during the surgery to implant the Device(s) by name, catalog number(s) and lot number(s): _____

   _____

   _____

   _____

   D. Did you receive the Device(s) at issue in connection with revision of another hip replacement system or component?

   Yes_____ No _____

   If you answered "Yes," identify the make and model of the components that were revised during the surgery in which the Device(s) at issue was implanted and the reason for the revision:

   _____

   _____

   _____

   E. Name and Address of Implanting Surgeon(s):

   _____

   _____

   _____

   F. Name and Address of Hospital(s) or Clinic(s) where implant surgery(ies) was/were performed:

   _____

IV. REVISION INORMATION

1. Provide the date of *each* revision surgery you have undergone, if any, and the name and address of the surgeon(s) who performed *each* revision surgery: _____

2. Provide the name and address of the facility at which each revision surgery was performed:

3. Set forth which components of your hip replacement were removed/explanted during each revision surgery: _____

   a. Were the explanted components preserved? Yes _____ No _____

   b. If Yes, identify by name and address the person or entity that currently has possession of the explanted components, and also identify all persons/entities who have had possession at any time since removal/explantation, including the dates of possession (chain of custody):

4. Provide the name of the manufacturer of and identification information for each of the replacement components implanted during each revision surgery: _____

5. Did you pay for your revision surgery and all related care?

   Yes _____ No _____ In Part _____

   a. If Yes, provide the amount paid by you: _____

   b. If No or In Part, state who or who else paid for the revision surgery: _____

   _____

   c. Provide the approximate amount paid by each person and entity and identify each person and insurance carrier, including but not limited to payments by Medicare and Medicaid, and for carriers, provide the name, address, and policy number:

   _____

   _____

6. Did you pay for your initial surgery[1] and all related care?

   Yes _____ No _____ In Part _____

   a. If Yes, provide the amount paid by you: _____

   b. If No, or In Part, state who or who else paid for the surgery and all related care: _____

   _____

   c. Provide the approximate amount paid by each person and entity and identify each person and insurance carrier, including but not limited to payments made by Medicare and Medcaid, and for carriers, provide the name, address, and policy number:

   _____

   _____

7. If you have not had your Device(s) removed surgically, has a date been scheduled for the surgery to remove/replace the Device(s)? Yes _____ No _____

If Yes, please state:

The date(s) scheduled for the surgery to remove/replace the Device(s): _____

The name and address(es) of the surgeon(s): _____

_____

[1] "Initial surgery" refers to the surgery during which the subject Device was implanted, even if the Device was implanted as part of a revision of an earlier hip replacement.

The name and address(es) of the hospital(s) where the surgery will be performed: _____

_____

The reason for surgery: _____

8. Has any doctor or other healthcare provider told you that you need to have your Device(s) or any other component(s) of your hip replacement system removed?

   Yes _____ No _____

   If Yes, please provide the name and addresses of each such doctor or healthcare provider and the dates and substance of those discussions, including identity of the component(s) requiring removal: _____

   _____

9. Has any doctor or other healthcare provider told you that any medical condition(s) prevents you from having your Device(s) or any other components of your hip replacement system removed? Yes _____ No _____

   If Yes, please provide the name and address of each such doctor or healthcare provider and the dates of those discussions, including identify of the components discussed: _____

   _____

10. Has any doctor or other healthcare provider told you that you required a revision of the Device(s) due to a problem or defect in the Device(s)? If yes, identify each such doctor or healthcare provider (including names and addresses), provide date(s) (including month and year) you were told and describe in detail exactly what you were told regarding a problem or defect in the Device(s):_____

    _____

    _____

11. Have you had discussions with any doctor or other healthcare provider about whether your claimed injury(ies) is related to the Device(s) at issue?

    Yes _____ No _____

a. If Yes, identify each such doctor or healthcare provider with whom you had such discussions by name and address and the dates and substance of those discussions: _____

_____

b. If Yes, identify any individuals who were present during the discussions by name and address and the dates of the discussion for which each individual was present: _____

_____

12. Have you received any other treatment or testing related to your Device(s)?

Yes _____ No _____

If Yes, state:

Date	Facility Name	Address and Phone Number	Reason	Results

13. Do you claim that the Device(s) disassociated from the femoral stem? Yes _____ No _____

If Yes, describe how and when you became aware that disassociation occurred and the circumstances surrounding the occurrence. _____

_____

_____

_____

V. OTHER PROSTHESES/IMPLANTS

1. Prior to receiving the Device(s) at issue, had you ever received any other joint prosthesis or implant?

Yes _____ No _____

2. Identify the type of other joint prosthesis or implant(s) received: _____

_____

3. Provide the date(s) (including month(s) and year(s)) you received the other joint prosthesis or implant(s):_____

4. Set forth the name(s) and address(es) of the surgeon(s) who performed your other joint prosthesis or implant surgery(ies): _____

_____

5. Set forth the name(s) and address(es) of the hospital at which your joint prosthesis or implant surgery(ies) were(was) performed: _____

_____

6. Date(s) (including month(s) and year(s)) of any revision surgery(ies) you underwent for the other joint prosthesis or implant(s) referenced in response to this question: _____

_____

7. Name(s) and address(es) of the surgeon(s) who performed your revision surgery(ies) for the other joint prosthesis or implant(s) referenced in response to this question: _____

_____

_____

8. Name(s) and address(es) of the hospital(s) at which your revision surgery(ies) was(were) performed for the other joint prosthesis or implant(s) referenced in response to this question: ___

_____

9. Reason(s) for your revision surgery(ies) for the other joint prosthesis or implant(s) referenced in response to this question: _____

_____

VI. INFORMATION AND HISTORY REGARDING RECEIPT OF THE DEVICE(S) AT ISSUE

1. Describe the condition for which the Device(s) was(were) implanted:

_____

_____

2. Who diagnosed you with the condition(s) for which you received the Device(s)? Identify the doctor or other healthcare provider by name and address: _____

_____

3. Did you request that the Device or implant system that you received be used in Your surgery(ies)?

Yes _____ No _____

If No, who suggested that you receive the Device or implant system that you received? Identify the doctor or other healthcare provider or other individual by name and address: _____

_____

4. Before the implantation of the Device(s), did you receive non-surgical treatment for your hip?

Yes _____ No _____

a. State the period during which you received non-surgical treatment: _____

_____

b. State the nature of the non-surgical treatment (e.g., rest, physical therapy, medication, injections): _____

_____

c. State the name and address of all doctors or health care providers involved in your non-surgical treatment: _____

_____

5. Did you read or rely upon any documents (including brochures, DVD's, etc.) or other information from Howmedica Osteonics Corp., which may have been referred to as "Stryker Orthopaedics," in making your decision to have the Device(s) implanted?

Yes _____ No _____

If Yes:

a. Identify each document/source of information: _____

b. State when you read the document/received the information: _____

c. State how you obtained the document or information: _____

d. Do you have a copy of the document(s)? If so, please produce a copy of it together with your response.

Yes _____ No _____

If you no longer have the document or written information in your possession, describe the information that you received to the best of your ability: _____

_____

6. Prior to your surgery, did you read or rely upon any documents, brochures, DVD's or other information relating to the Device(s) you received?

Yes _____ No _____

If Yes:

a. Identify each document/source of information: _____

b. State when you read the document/received the information: _____

c. State how you obtained the document or information: _____

d. Do you have a copy of the document(s) in your possession? If so, produce a copy together with your response.

Yes _____ No _____

If you no longer have the document or written information in your possession, describe the information that you received to the best of your ability: _____

_____

7. Were you given any verbal or written instructions, warnings or other information regarding the Device(s) or implant system?

Yes _____ No _____

a. If Yes, when did you receive the information? _____

b. Who gave you the information? _____

c. Do you have the written information in your possession? If so, please produce a copy of it with your response.

Yes _____ No _____

d. Describe the oral instructions and/or warnings you received regarding the Device(s) or implant system: _____

_____

8. Were you given any verbal or written instructions, warnings or other information regarding the implantation surgery?

   Yes _____ No _____

   a. If Yes, when did you receive the information? _____

   b. Who gave you the information? _____

   c. Do you have the written information in your possession? If so, please produce a copy of it with your response.

      Yes _____ No _____

   d. Describe the oral instructions and/or warnings you received regarding the implantation surgery: _____

      _____

9. Did you view or hear any commercials or advertisements regarding the Device(s) prior to your implantation surgery(ies)?

   Yes _____ No _____

   If Yes, state:

   a. Date(s) (including month(s) and year(s)) you viewed or heard the commercial(s) or advertisement(s): _____

   b. Identify the city and state in which you were located when you viewed or heard the commercial(s) or advertisement(s): _____

   c. Identify each person present when you viewed or heard the commercial(s) or advertisement(s): _____

   d. If available, provide a copy of the commercial(s) or advertisement(s) viewed or heard and identify any spokesperson(s), and, if not available, provide a summary of same: _____

      _____

      _____

10. Have you been told that the Device you received has been recalled? _____

    If Yes:

b. State how and when you learned that your Device(s) has/have been recalled? _____

_____

c. Have you discussed the recall with any doctor or other healthcare provider and, if so, identify each doctor or healthcare provider, their address(es), and the approximate date(s) and substance of the discussion(s). _____

_____

_____

11. Have you had any communications with any present or former employees of Howmedica Osteonics Corp., which may have been referred to as "Stryker Orthopaedics," or any Device distributor or sales representative concerning the Device or matters in any way related to this lawsuit? Yes _____ No _____

If Yes, for each communication, state:

a. Date of the communication: _____

b. Name of the person(s) with whom you communicated: _____

c. Mode of communication (e.g., in person, by phone, email or mail, etc.): _____

d. Describe the substance of the communication (attach copies of any related documents):

_____

_____

VII. HEALTHCARE PROVIDERS

1. Identify each doctor or healthcare provider (including but not limited to family/primary care physicians, physical therapists, chiropractors, practitioners of the healing arts) from whom you have received medical care and treatment not related to your legs, hips or knees for the period ten (10) years before your first hip surgery to the present.

Name and Specialty	Address and Phone Number	Approximate Dates/Years of Visits	Reason

2. Identify each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) not related to your legs, hips or knees for the period ten (10) years before your first hip surgery to the present.

Name	Address	Admission Date(s)	Reason	Type of Surgery (if applicable)	Name of Surgeon (if applicable)

3. Identify each doctor or healthcare provider (including but not limited to family/primary care physicians, orthopedist, orthopedic surgeon, physical therapists, chiropractors, practitioners of the healing arts) whom you have seen for medical care and treatment related to your legs, hips or knees at any time through the present.

Name and Specialty	Address and Phone Number	Approximate Dates/Years of Visits	Reason

4. Identify each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) related to your legs, hips or knees at any time through the present.

Name	Address	Admission Date(s)	Reason	Type of Surgery (if applicable)	Name of Surgeon (if applicable)

5. Identify each facility at which radiographs (x-rays, ultrasounds, MRIs, CT scans, bone scans) were taken of your legs, hips or knees at any time through the present.

Name	Address and Telephone Number	Approx. Date Taken	Reason

6. Identify each laboratory at which your blood was tested in the last 20 years for blood levels of any metals including cobalt and chromium.

Name	Address and Telephone Number	Approx. Date Taken	Reason	Results (if known by you)

7. Identify each laboratory at which your blood was tested for any reason from five (5) years prior to your first hip implant surgery through the present.

Name	Address and Telephone Number	Approx. Date Taken	Reason	Results (if known by you)

8. Identify each pharmacy, drugstore or any other facility or supplier (including but not limited to mail order pharmacies) where you ever received any prescription medication for the period seven (7) years before your first hip surgery to the present.

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approx. Dates/Years You Used Pharmacy/Supplier

VIII. MEDICAL BACKGROUND AND HISTORY

1. Current Height: _____

2. State your weight at the following times:

   a. Current: _____

   b. Time of implant at issue: _____

   c. Time of revision surgery (if any): _____

3. Smoking History

   a. Have you ever smoked cigarettes?

      Yes _____ No _____

      State amount smoked: _____ packs per day for _____ years, during the years _____ to _____.

   b. Have you ever smoked cigars or pipe tobacco or used smokeless tobacco?

      Yes _____ No _____

      State amount smoked/utilized: _____ cigars/pipes/smokeless tobacco per day for _____ years, during the years _____ to _____.

4. For the period of time five (5) years before your first hip surgery up to the present, set forth the amount and type(s) of alcoholic beverages you consume(d) on a weekly or monthly basis on average and the type. If the amount has materially changed over this period of time, please describe/explain.

   _____

   _____

5. Have you ever experienced an allergic reaction, including to any food, medication, jewelry or metal?

   Yes _____ No _____

   If Yes, please state the following:

Type of Food, Medication, Jewelry or Metal	When Allergy Diagnosed	Symptoms of Allergy	Name & Address of Health Care Provider Who Diagnosed Allergy	Treatment Received, if any

6. Are you claiming in this lawsuit that you have suffered mental or emotional distress as a result of your receipt of the Device?

   Yes _____ No _____

7. ***Only if you are claiming damages for mental or emotional distress in this lawsuit as a consequence of your receipt of the Device(s)***, state whether you have experienced or been

treated for any psychological, psychiatric or emotional condition prior to developing the injury(ies)/condition(s) alleged, including, but not limited to, panic attacks, anxiety, post traumatic stress disorder, depression, thoughts of hurting yourself or other people, schizophrenia, bipolar disorder, personality disorders (e.g. obsessive compulsive disorder, paranoid, borderline, histrionic), generalized anxiety disorder, social phobia/anxiety disorder, mania, poor sleep, poor concentration, suicidal thoughts/attempts and/or drug or alcohol addiction.

Yes _____ No _____

If Yes, state:

a. Name and address of each healthcare provider who treated you: _____

_____

b. Conditions for which treated: _____

c. Dates (including months and years) treated: _____

d. Medications prescribed for such condition(s): _____

8. Other Conditions

a. To the best of your knowledge or understanding, have you ever experienced or been diagnosed with any of the following conditions from the time beginning ten years before your first hip surgery to the present? Please select Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart.

Condition Experienced or Diagnosed	Yes	No	I Don't Know
Acetabular perforation			
Allergies, such as hay fever, asthma, eczema, hives, sensitivity to drugs or other substances, including allergic reactions to metals or minerals, including jewelry			
Aseptic Lymphocyte-Dominated Vasculitis-Associated Lesion (ALVAL)			
Any pathological condition of the acetabulum (e.g., arthrokatadysis)			
Arthritis (e.g., osteoarthritis, traumatic arthritis, degenerative arthritis)			
Arthritis- Rheumatoid			
Associated Reactions to Metal Debris (ARMD) (including Adverse Local Tissue Reaction (ALTR))			
Avascular necrosis			
Neck or spinal injury or medical condition			
Bone fracture			

Condition Experienced or Diagnosed	Yes	No	I Don't Know
Cancer (including blood cancers such as leukemia)			
Charcot's or Paget's disease			
Chronic Fatigue Syndrome			
Chronic hip, leg or lower back pain			
Colitis or Ulcerative Colitis treated with medication			
Congenital dysplasia of the hip			
Crohn's Disease treated with medication			
Deep Vein Thrombosis (DVT)/blood clots			
Degenerative joint or disc disease			
Diabetes			
Disabilities of joints			
Dislocation or subluxation of the hip joint			
Drug and/or alcohol addiction			
Elevated Metal Ion Levels (Blood/Serum/Urine/Tissue)			
Femoral head dissociation (i.e., head coming apart, either partially or completely from the femoral stem)			
Fracture or visible degradation/deterioration of the femoral stem trunnion			
Femoral shaft perforation, fissure or fracture			
Fibromyalgia			
Heart attack/Myocardial Infarction (MI)			
Ileitis treated with medication			
Immunodeficiency disorders			
Infections lasting longer than a week or occurring more frequently than monthly			
Inflammatory bowel disease treated with medication			
Itching (persistent lasting more than one week) treated with medication			
Joint pain lasting more than a few days			
Leg Length Discrepancy			
Lupus			
Lyme Disease			
Neuromuscular compromise or vascular deficiency			
Obesity			
Osteolysis			
Periarticular calcification or ossification			
Peripheral neuropathies or nerve damage			
Poor bone quality (e.g., osteoporosis)			
Reflex Sympathetic Dystrophy Syndrome (RSDS) or Complex Regional Pain Syndrome (CRPS)			
Renal insufficiency			
Skeletal hyperostosis			
Slipped Capital Femoral Epiphysis			

Condition Experienced or Diagnosed	Yes	No	I Don't Know
Trochanteric fracture			
Tumors or Pseudo-tumors			

b. For each condition for which you answered "Yes" in the previous chart, provide the information requested below:

Condition You Experienced	Approx. Date of Onset	Name, Address and Phone Number of Treating Physician (if any)	Treatment Received

9. State whether you ever underwent any of the following treatments or diagnostic procedures and provide all information requested:

a. Joint-related, non-implant, surgeries, other than what has previously been identified above, including specifying the condition(s) for which the surgery was performed:

Surgery and condition(s) for which it was performed: _____
_____
Date (month and year): _____
Treating physician and address: _____
_____
Hospital and address: _____
_____

b. Any other surgeries, from ten (10) years before your first hip implant surgery to the present, specifying the condition(s) for which the surgery was performed:

Surgery and condition(s) for which it was performed: _____
_____
Date (month and year): _____
Treating physician and address: _____
_____
Hospital and address: _____
_____

c. Other than the implantation of the Device(s) at issue, have you had implanted in your body any other medical product, not joint-related, of any kind (excluding dental fillings, crowns and bridges)?

Yes _____ No _____

If Yes, provide the following information:

Product Name: _____
Date of Procedure Placing the Device: _____
Name and Address of Implanting Physician: _____
Condition Sought to be Treated: _____
Any complications encountered with device or procedure: _____
Does the device remain implanted inside of you today? Yes _____ No _____

10. Have you ever participated in any clinical trials or studies relating to any medical devices, drugs or treatments for any joint-related medical condition(s)?

Yes _____ No _____ I am unaware if I have participated in any such clinical trials or studies _____

If Yes, set forth:

Name of trial or study: _____
Sponsor of trial or study: _____
Drug, device or treatment studied: _____
Purpose of the drug, device or treatment studied: _____
Name and address of the investigator in charge of your care and treatment in the trial or study:
_____
The dates (months and years) you participated in the trial or study: _____

IX. MEDICATIONS

1. List all medications (prescription and over the counter, including any vitamins) you currently take.

Medication	Dose/Frequency/ Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, list each prescription or over the counter medications (including vitamins) you have taken regularly (i.e., for more than 90 days) starting from five (5) years prior to your first hip implant surgery to the present, other than those already identified above.

Medication	Dose/Frequency/ Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

3. To the extent not already provided, list each prescription or over the counter medicine (including vitamins) you have taken during the time the Device(s) at issue was in your body.

Medication	Dose/Frequency/ Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

4. To the best of your recollection, state whether you took or were treated with any steroids from ten (10) years prior to the date of your first hip implant surgery through the present. If so, provide the names of the steroids you have used, the dates (including months and years) you took the steroids, how frequently you took the steroids, the names and addresses of the doctors who prescribed the steroids and addresses of the pharmacies at which you fill the steroid prescription.

_____

_____

_____

X. INSURANCE INFORMATION

1. Are you a Medicare recipient? Yes _____ No _____

If Yes, please specify the following:

(a) State your Health Insurance Claim Number (HICN): _____

(b) Provide the date on which you first began receiving such benefits: _____

[Please note: If you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2), also known as the Medicare Secondary Payer Act.]

2. Has any insurance company or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning ten (10) years before the date of your first hip surgery to the present?

Yes _____ No _____

If Yes, then as to each company, separately state:

Name of company: _____
Address of company: _____
The account/policy number or designation: _____
Dates of coverage: _____
When claims were made: _____

3. Have you ever been denied life insurance or medical insurance for reasons relating to your medical or physical condition(s)?

Yes _____ No _____

If Yes, state the date (including month and year), the name of the company and the company's stated reason for denial: _____

_____

4. ***(Answer this question only if you are claiming damages for mental or emotional distress in this lawsuit.)*** Have you ever been denied life insurance or medical insurance for reasons relating to your mental or emotional condition(s)?

Yes _____ No _____

If Yes, state the date (including month and year), the name of the company and the company's stated reason for denial: _____

_____

XI. PRIOR CLAIM INFORMATION

1. Have you ever been involved in an accident, incident or other event as a result of which you suffered any personal injuries to your legs, hips, knees or pelvic area? Yes _____No _____

   If Yes, provide the following information and attach copies of any accident or incident reports:

Place and Date of Accident	Circumstances, Nature, Location, and Extent of Injury	Nature of Activity at Time of Injury	Names and Addresses of Treating Physician(s)

2. Have you ever filed a lawsuit or made a claim against anyone related to any bodily injuries, including but not limited to a medical malpractice lawsuit or a lawsuit against a pharmaceutical and/or medical device company?

   Yes _____ No _____

   If Yes, provide the following information and attach copies of all pleadings, releases or settlement agreements, and deposition transcripts:

Party You Sued/Made Claim Against	Court in Which Suit Filed/Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

   If an insurance carrier was involved in the claim(s) or complaint(s), provide the policy number, the claim number, the claims representative and the determination made by the insurance carrier:

   _____

   _____

3. Have you or your spouse/partner ever declared bankruptcy since the date of your original hip implantation surgery? Yes _____ No _____

If Yes, when and in what court was the bankruptcy petition filed? (include the docket number of the petition): _____

_____

4. Have you ever been out of work for more than thirty (30) consecutive days for reasons related to your health, beginning ten (10) years before the date of your first hip implant surgery to the present? If yes, set forth the dates (including months and years) and the reason.

Yes _____ No _____

Dates: _____
Reason(s): _____
Dates: _____
Reason(s): _____

5. Have you ever been on or applied for workers' compensation, social security, and/or state or federal disability benefits?

Yes _____ No _____

If Yes, then as to each application, separately state the following and attach any documents you have which relate to the application and/or award of benefits:

a. Date (or year) of application: _____

b. Place of employment, including name, address and telephone number, at the time of application: _____
_____

c. Job description/duties at the time of application: _____
_____

d. Type of benefits: _____

e. Nature of claimed injury/disability: _____

f. Period of disability: _____

g. Amount awarded: _____

h. Basis of your claim: _____

i. Was claim denied? Yes _____ No _____

j: To what agency or company did you submit your application: _____

_____

k. Claim/docket number, if any: _____

XII. INJURIES & DAMAGES

1. Are you claiming any physical injuries, condition or illness as a result of the Device(s)?

Yes _____ No _____

a. If yes, describe in detail all of the physical injuries, conditions or illnesses that you claim are related to the Device(s) and indicate when the symptoms began: _____

_____

_____

_____

_____

_____

b. For each of the above-described injuries, conditions or illnesses that are continuing, please state your current condition and describe any on-going limitations and/or symptoms that you claim were caused by or are related to your Device(s): _____

_____

_____

_____

_____

2. Identify each injury or illness you suffered either during or subsequent to the revision surgery:

i. Disassociation of the femoral head Yes ☐ No ☐

ii. Debridement of Necrotic Tissue Yes ☐ No ☐

iii. Bone loss requiring bone grafting Yes ☐ No ☐

iv. Osteolysis Yes ☐ No ☐

v. Damage to abductor muscle requiring surgical repair beyond surgical technique Yes ☐ No ☐

vi. Damage to the abductor muscle too extensive or severe to repair

Yes ☐ No ☐

vii. Unintended Femur Fracture Yes ☐ No ☐

viii. Osteotomy for Stem Removal Yes ☐ No ☐

ix. Placement of Cabling or Hardware for Fracture Yes ☐ No ☐

x. Infection Yes ☐ No ☐

Infection-related treatment:

1. IV Antibiotics Yes ☐ No ☐

2. Antibiotic Spacer Surgery Yes ☐ No ☐

3. Surgical Placement of Wound Vacuum Yes ☐ No ☐

4. Irrigation and Debridement Surgery Yes ☐ No ☐

xi. Complications of Anesthesia Yes ☐ No ☐

xii. Hip Dislocation Yes ☐ No ☐

1. Closed Reduction Yes ☐ No ☐

Number of Closed Reductions _____

2. Open Reduction Yes ☐ No ☐

Number of Open Reductions _____

xiii. Additional surgery(ies) for Complications of Revision Yes ☐ No ☐

xiv. Other: _____

a. Provide the approximate date of treatment for each condition, and identify the name and address of each healthcare provider that you have seen for these problems:

Condition You Experienced	Approx. Dates of Treatment	Name, Address and Phone Number of Healthcare Provider (if any)

b. Did you ever suffer any of the injuries or conditions identified in this section prior to having been implanted with the Device(s)? If yes, identify the date (including month and year) of diagnosis and who diagnosed the condition at that time: _____

_____

_____

c. Do you claim that your receipt of the Device(s) worsened a condition(s) that you already have or had in the past?

Yes _____ No _____

If Yes, describe the preexisting injury(ies) or condition(s); whether you had already recovered from that injury(ies) or condition(s) before you received the Device(s); and date of recovery, if applicable:

_____

_____

3. Do you claim any psychological or psychiatric injury as a consequence of having the Device?

Yes _____ No _____

If Yes, please state the following as it pertains to your treatment for any claimed psychiatric and/or psychological condition(s):

Condition	Name and Address of Mental Healthcare Provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

4. Since you received your Device(s), have you posted a comment, letter, message, blog entry or posting on any social media, internet site or in a newspaper in which you have discussed or described your Device(s) experience, injury, disability, pain or physical complaints related to the Device(s), or your physical or emotional health? (You should include postings on social network sites such as Twitter, Facebook, MySpace, LinkedIn or "blogs.")

Yes _____ No _____

If so, identify where and when you made such postings and set forth the substance of what was posted. Provide copies of any posts identified.

_____

_____

_____

5. Since you received your Device(s), have you deleted or destroyed any comments, letters, messages, blog entries or postings on any social media, internet site or in a newspaper which discussed or described your Device(s) experience, injury, disability, pain or physical complaints related to the Device(s), or your physical or emotional health? (You should include postings on social network sites such as Twitter, Facebook, MySpace, LinkedIn or "blogs.")

Yes _____ No _____

If you answered "Yes," identify where and when you deleted or destroyed any such posting, the substance of the posting, and the reason for the deletion or destruction.

_____

_____

_____

6. Are you making a claim for lost wages or lost earning capacity?

Yes _____ No _____

a. If yes, describe your claim and attach your W-2 forms for the five (5) years before your first hip implant surgery through the present. The description of your claim must include the total amount of time (and amount of income) you have lost or will lose from work as a result of any condition that you claim or believe was caused by the Device(s), and an explanation of how those amounts were calculated:

_____

_____

_____

b. If you claim a loss of earnings, state your earned income from five (5) years prior to your first hip implant surgery through the present:

YEAR	INCOME

c. If you claim a loss of earnings, identify your accountant for the five (5) years prior to your first hip implant surgery through the present, and identify the individual(s) who prepared your tax returns for the same period of time: _____

_____

_____

XIII. MEDICAL AND OUT-OF-POCKET EXPENSES

1. State the amount of medical expenses, by provider, that you have incurred, including amounts billed to insurers and other third party payors, which are related to any condition which you claim or believe was caused by the Device(s) for which you seek recovery in this action:

Name and Address of Provider	Dates of Treatment	Amount of Medical Expenses
		$
		$
		$
		$

For any medical expenses claimed above, have those expenses been reimbursed by any third party?
Yes _____ No _____

If Yes, identify which expenses, the amount reimbursed, the date reimbursed and identify the reimbursing third party: _____

_____

2. For any liens or potential liens on a recovery in this action, identify the name and address of the lienholder, set forth the nature and amount of the lien, and provide an itemized list of payments for which a lien has been or may be asserted: _____

_____

_____

XIV. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. If you are completing this PFS on behalf of an individual who is deceased, then please state the following from the Death Certificate of the individual, and attach a copy of death certificate and the letters of administration:

Date of death: _____
Place of death (city, state and country): _____
Facility or location where death occurred: _____
Name of physician who signed death certificate: _____
Cause of death: _____

2. If you are filling this out on behalf of an individual who is deceased, was an autopsy performed on the decedent?

Yes _____ No _____

If Yes, please state the following from the Autopsy Report of the individual, and attach a copy of the Autopsy Report:

Date of autopsy: _____
Name of physician who performed autopsy: _____

XV. FACT WITNESSES

Please identify all persons whom you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, address and relationship to you:

Name:
Address:
Relationship to you:

Name:
Address:
Relationship to you:

XVI. DOCUMENT DEMANDS

Please produce the following documents:

1. All medical records from any physician, hospital or healthcare provider who has treated you for any injury, illness and/or disease identified in response to this Plaintiff Fact Sheet.

2. Please attach a copy of: (1) the operative report(s) for the implant of the Device(s) at issue in this case, including the product identification information/stickers where available, and, if the Plaintiff has undergone one or more revision surgeries, (2) the operative report(s) and product identification information/stickers from the surgery(ies) to remove and replace the Device(s) at issue in this case.

3. All radiographs (x-rays, ultrasounds, MRI's, CT scans) that relate to the condition and injuries alleged in Plaintiff's Complaint, show any portion of Plaintiff's hip and/or depict the Device(s).

4. All laboratory reports and results of blood tests performed on Plaintiff that show the level of cobalt and chromium ion levels in the blood.

5. All laboratory, histology, cytology and/or pathology (originals and recuts) specimens pertaining to Plaintiff, including but not limited to specimens taken from Plaintiff during any joint replacement or revision surgery.

6. All documents and/or notices received by Plaintiff with respect to third party lien holders, including but not limited to, insurance companies, workers compensation, Medicare/Medicaid and/or other governmental entities.

7. All records of any other expenses allegedly incurred as a result of the injuries alleged in the Complaint.

8. All photographs or videos of Plaintiff's surgery(ies), all photographs or videos depicting the Device(s) at issue, and all photographs and videos of Plaintiff which show Plaintiff's condition since the date of the original implantation.

9. All recordings, including but not limited to, audio recordings and video recordings, chronicling the injuries alleged in the Complaint.

10. All documents (including photographs or images) that depict the injuries, and/or damages alleged in the Complaint, including, but not limited to, any audio tapes, CDs, videotapes, DVDs, or photographs depicting any rehabilitation or treatment related to the injuries alleged in the Complaint.

11. Any documents, including but not limited to, literature or warnings received by you from surgeons, physicians, or other healthcare professionals who have treated you for any condition related to the Device(s).

12. Any and all notes or memoranda prepared by Plaintiff reflecting or summarizing communications with his/her implanting surgeon(s) and/or any other healthcare provider

regarding the Device(s) at issue in this case, the surgery to implant the Device(s), and/or Plaintiff's health or medical condition or treatment.

13. Copies of all advertisements or promotions for the Device(s) received or reviewed before filing this action.

14. Any documents including diaries, journals, calendars, emails, texts, letters, or other notes prepared by Plaintiff or Plaintiff's representative, concerning Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, the Device(s), Plaintiff's injury, disability, pain or physical complaints related to the Device(s) and/or Plaintiff's physical and emotional health.

15. Any postings on websites, blogs or social media accounts (e.g. Facebook, MySpace, Twitter, Instagram, Vine, LinkedIn) prepared by Plaintiff or Plaintiff's representative concerning Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, the Device(s), Plaintiff's injury, disability, pain or physical complaints related to the Device(s) and/or Plaintiff's physical and emotional health.

16. All documents that refer or relate to the Device(s) at issue obtained from the Food and Drug Administration or other government agencies.

17. All documents you received concerning the recall of certain lots of LFIT Anatomic CoCr V40 Femoral Heads, whether created by Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, your healthcare provider or any other third party.

18. Decedent's death certificate, letter of administration and/or autopsy report (if applicable).

19. All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first hip surgery.

20. Documents that relate in any way to your application for, or award of, workers' compensation benefits for any injury or condition during the period from ten years before your first hip surgery to the present.

21. Copies of any accident report(s) related to any accident or event, in which or as a result of which you suffered any personal injuries for the ten (10) years before your first hip implant surgery to the present.

22. Copies of all pleadings, releases or settlement agreements and deposition transcripts related to any lawsuit or claim against anyone related to any personal injury.

23. Documentation of any agreement you have entered into, other than your retention agreement with your attorney or any lien or repayment obligations related to medical expenses, which creates an obligation to pay or repay money that is contingent on the outcome of your case.

24. Copies of any documents from Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, that you read or relied on in making your decision to have the Device(s) implanted.

25. Copies of any written instructions, warnings or other information received from any source regarding the implantation of the Device(s), including any informed consent form.

26. Copies of any communications with any present or former Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, employee, any Device distributor or sales representative concerning the Device(s) or matters in any way related to this lawsuit.

27. All documents, including but not limited to medical bills, related to the medical expenses (whether paid by you, insurers, Medicare/Medicaid or other third parties) for which you seek recovery in this lawsuit.

AUTHORIZATIONS

Complete and sign the attached Authorizations.

VERIFICATION

I, _____, declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge upon information and belief, that I have supplied all the documents requested in this Plaintiff Fact Sheet, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

Date: _____ _____

Signature

ACKNOWLEDGEMENT ON USAGE OF MEDICAL AUTHORIZATIONS

I, _____, acknowledge and understand that the attached authorizations will be sent by Shook, Hardy & Bacon L.L.P. to all health care professionals and/or entities who have provided me health care services/treatment.

I acknowledge and understand that the names of these health care professionals and/or entities will be inserted into the authorization by Shook, Hardy & Bacon L.L.P. upon identification of said professionals and/or entities.

_____
(Signature)

_____
(Name - Print)

_____
(Date)

Shook, Hardy & Bacon L.L.P.
(Law Firm Name)

_____
(Witness Signature)

600 Travis, Suite 3400
Houston, Texas 77002-2926
(Law Firm Address)

_____
(Witness Name - Print)

SHOOK, HARDY & BACON LLP

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO 45 C.F.R. 164.508

Patient Name:

Identification: Date of Birth _____ Soc. Sec. # _____
Parents Name/Previous Name(s) _____

Provider: Organization, Individual, or Class of Persons) _____
(Who is releasing the information)

Address (leave blank if used for Class of Persons)

Requestor: Name DISCOVERY RESOURCE
(to whom the information will be provided) Address **1511 West 34th Street**
Houston, Texas 77018
(713) 2223-3300

Information Requested: I authorize the disclosure of all protected health information in any form (including oral, written and electronic) for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected health information spanning the time period to the present date including, but not limited to, the following:

- All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or health care providers;
- All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;
- All radiology films; mammograms; myelograms; CT Scans; photographs; bone scans; pathology, cytology, histology, autopsy, immuno-histo-chemistry specimens; cardiac catheterization videos/CDs/films/reels; and echocardiogram videos;
- All pharmacy prescription records, including, but not limited to: NDC numbers and drug information handouts/monographs
- All billing records, including, but not limited to: all statements, itemized bills, and insurance records.

Purpose of Release: ☒ For the purpose of review and evaluation in connection with a legal claim. ☐ Other _____

This authorization is effective for one year, or when the following event occurs: **The final resolution of all claims related to [redacted] *vs. Howmedica Osteonics Corporation, et al.*** I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to **Shook, Hardy & Bacon L.L.P. Attn: Gene Williams, 600 Travis St., Suite 3400, Houston, Texas 77002**. 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. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule. Any facsimile, copy or photocopy of the authorization authorizes you to release the records requested herein.

Signature of Patient if 18 years of age or older _____ **Date** _____

Signature of Parent or Legal Representative _____ **Date** _____

Relationship to Patient, if not signed by Patient _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

In addition to the authorization and other provisions contained above, hereby incorporated by reference, I authorize: (I) the release of data and information to Shook, Hardy & Bacon LLP; and (II) Shook, Hardy & Bacon L.L.P's re-disclosure of the data and information to its consultants, experts, agents, and/or other counsel; any and all data, notes, records, reports, and/or any other documents and information relating to:

√ 1. Substance Abuse (Alcohol/Drug) √ 2. Mental Health (Includes psychological testing) √ 3. HIV-related information (AIDS related testing)

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175); Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

Signature of Patient if 18 years of age or older_____ **Date**_____

Signature of Parent or Legal Representative_____ **Date**_____

Relationship to Patient, if not signed by Patient_____

Authorization for Disclosure of Health Information

[Please Print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Health Plan (your health insurance carrier or HMO) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Section A. Member Information (individual whose information will be released)

Name: (First, Middle, Last, Title)	Member ID Number:	Date of Birth: (Month/Day/Year)
Address: (including zip code)	Telephone Number: (including area code)	

Section B. Health Plan (organization that will release your information)

I authorize ________________________ to release my protected health information as described below.
(Health Plan name on your ID card)

Section C. Recipient (person or organization that will receive your information)

Person's Name or Organization: Discovery Resource	Telephone Number: (Including area code) 713/223-3300
Address: (including zip code) 1511 West 34th Street, Houston, Texas 77018	Fax Number: (if available) 713/228-3311

Section D. Description of the Information to be Released (what type of information will be released)

Check ONLY ONE box:

☐ **Psychotherapy notes** – Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you may not check another box below.

☐ **All information related to the provision of and payment for my health care benefits or services.***

☐ **Specific information as described on the line below:***

____
Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

*NOTE: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information	________ (Initials)	HIV/AIDS	________ (Initials)
Substance/Alcohol Abuse	________ (Initials)	Mental/Behavioral Health	________ (Initials)

Purpose of Release: ______________________________
Examples: At my request; To resolve my appeal; To assist with my health insurance services

Section E. Expiration (when this authorization will end)*

This authorization will expire (Check ONLY ONE box):

☐ **When I revoke this authorization***

☐ **Upon the following date, event or condition*:** ________________________

*** The party identified in Section B must be notified in writing of the event/condition to cancel or revoke this authorization.**

Section F. Approval (You OR your Personal Representative must sign and date this form in order for it to be complete)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: [illegible] authorize the release of my protected health information as described above.	**Personal Representative Information:** [illegible]
__________ (Print Name)	__________ (Printed Name of Personal Representative) __________ (Description of Representative's Authority)
__________ (Signature of Member)	
__________ (Date)	______ (Date) __________ (Signature of Personal Representative) (___) ______ (Telephone Number)

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

08161 (11/16)

Instructions - Authorization for Disclosure of Health Information

This form is used for you or your Personal Representative to authorize the Health Plan to release your protected health information to another person or organization at your request.

"Protected health information," means individually identifiable health information. It is information about you, including your name, address and medical information and may relate to your past, present or future physical or mental health or condition. The Health Plan maintains information that may include eligibility, benefits, claims or payment information.

Section A: Member Information: (Individual whose information will be released)

Print your complete name, member ID number, address, date-of-birth and telephone number.

Important: Provide the Member ID Number located on the front of your Health Plan identification card. Be sure to include any letters in front of the identification number.

Section B: Health Plan: (organization that will release your information)

The Health Plan is your insurance carrier or HMO that maintains information about you. Print the name of your Health Plan on the line provided.

Section C: Recipient: (person or organization that will receive your information)

The recipient is a person or organization that you choose to receive your protected health information from the Health Plan. You must provide all of the contact information in order for the information to be released.

- Identify the person, family member or organization to receive your information.
- Provide the contact information about the person, family member or organization to receive your information.

Section D: Description of the Information to be Released: (what your information will be released)

You must indicate or describe the information to be released. **Check ONLY ONE box that best describes your request.** There are three choices. The first choice is **Psychotherapy Notes.** The second choice is **All Information.** The third choice is **Specific Information** that you must describe on the line provided. **CHECK ONLY ONE BOX.**

If this authorization is to release psychotherapy notes, the Health Plan cannot release any other information unless you complete another Authorization to Release Information form.

- **Psychotherapy Notes** are notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session. These notes are separated from the rest of the individual's medical record. **Psychotherapy notes cannot be combined with an authorization to release any other type of information.**
- **All Information.** If you check this box, the Health Plan may release all information related to the provision of a payment for your health care benefits or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all of your information.
- **Specific Information.** By checking this box, you indicate that you want only specific information to be released. Describe the specific information on the line provided.

Purpose of Release. Provide a brief description of the reason you want this information released. The statement, "At my request" is sufficient.

IMPORTANT: State law requires that you give specific permission to release certain health information. Your initials are required on each line in order for the Health Plan to release information for HIV/AIDS, Substance/Alcohol Abuse, Genetic Information or Mental/Behavioral Health information.

Section E: Expiration: (when this authorization will end)

Print either an expiration date OR event, but not both. If an expiration event is used, the event must relate to the purpose of the release of information being authorized.

Section F: Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete)

Member Signature. If you are the individual whose information will be released, you must sign and date in this section.	**Personal Representative Information.** If you are the Personal Representative, the member's signature is not required. However, you must provide the requested information, signature and date. A copy of the legal authority, such as a Power of Attorney or other legal document, must be on file at the Health Plan or be submitted with this form.

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.
- **Then proceed to question 2B.**

Instructions for Completing Section 2B of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, in the space provided, write: "all information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, write "Exclude information about alcohol and drug abuse, mental health treatment and HIV" in the space provided. *You may also check any of the remaining boxes and include any additional limitations in the space provided.* For example, you could write "payment information". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example; Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

   Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters (for example, 123456789A).

   Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2b that apply to the type of information you want Medicare to give out.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

5. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

   If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

7. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) _____ **Medicare Number** (Exactly as shown on the Medicare Card) _____ **Date of Birth** (mm/dd/yyyy) _____

2. Medicare will only disclose the personal health information you want disclosed.

   2A: **Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:**

   ☐ Limited Information (go to question 2b)

   ☒ Any Information (go to question 3)

   2B: **Complete <u>only</u> if you selected "limited information". Check all that apply:**

   ☐ Information about your Medicare eligibility

   ☐ Information about your Medicare claims

   ☐ Information about plan enrollment (e.g. drug or MA Plan)

   ☐ Information about premium payments

   ☐ Other Specific Information (please write below; for example, payment information)

   _____

3. **Check only <u>one</u> box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   ☒ Disclose my personal health information indefinitely.

   ☐ Disclose my personal health information for a specified period only
   beginning: (mm/dd/yyyy)_____ and ending: (mm/dd/yyyy) _____

4. **Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:**

1. Name: Discovery Resource

   Address: 1511 West 34th Street

   Houston, Texas 77018

2. Name: _____

   Address: _____

   _____

3. Name: _____

   Address: _____

   _____

5. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

_____ _____ _____

Signature Telephone Number Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

_____

_____

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

_____

_____

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

6. **Send the completed, signed authorization to:**

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

7. **Note:**

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0930**. The time required to complete this information collection is estimated to average **15 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

AUTHORIZATION FOR RELEASE OF INFORMATION

TO:

In conjunction with pending litigation, you are hereby authorized to release to my attorneys, _____ and/or their authorized representatives or affiliated counsel, and to SHOOK, HARDY & BACON, L.L.P. Attorneys for Howmedica Osteonics Corp., and/or their authorized representatives, including but not limited to Discovery Resource, 1511 West 34th Street, Houston, Texas 77018, the following:

> Any and all records in your possession or under your control pertaining to the employment of _____, including but not limited to applications for employment, employee health files, descriptions of job functions, evaluation, reviews, and job performance summaries, payroll and earnings statements, and correspondence and memorandums regarding the undersigned.

This authorization is an information consent for the release of records, and I understand that I have a right to receive a copy of this Authorization upon request.

A copy of this signed Authorization shall be deemed as valid as the original

I understand that the information requested cannot be released without my specific consent.

These records shall be used or disclosed solely in connection with the current litigation and which involves the person named above. This authorization shall cease to be effective as of the date on which the litigation concludes.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon. I understand that once the information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

DATED: _____ _____

SIGNATURE

_____

DATE OF BIRTH

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) - - One SSN per request

Date of Birth: / / Date of Death: / /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose ONE of the following types of earnings or SSA must return this request.)

☐ **Itemized Statement of Earnings $115**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Year(s) Requested: to
Year(s) Requested: to

☐ Check this box if you want the earnings information CERTIFIED for an additional $33.00 fee.

☐ **Certified Yearly Totals of Earnings $33**
(Does not include the names and addresses of employers)
Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name	Discovery Resource		
Address	1511 West 34th Street	State	TX
City	Houston	ZIP Code	77018

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

Signature AND Printed Name of Individual or Legal Guardian	*SSA must receive this form within 120 days from the date signed* Date / /
Relationship (If applicable, you must attach proof)	Daytime Phone:
Address	State
City	ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information
Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings
Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are FREE to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, authorizes us to collect the information on this form. We will use the information you provide to identify your records and send the earnings information you request. Completion of this form is voluntary; however, failure to do so may prevent your request from being processed.

We rarely use the information in your earnings record for any purpose other than for determining your entitlement to Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

A complete list of routine uses for earnings information is available in our Systems of Records Notices entitled, the Earnings Recording and Self-Employment Income System (60-0059), the Master Beneficiary Record (60-0090), and the SSA-Initiated Personal Earnings and Benefit Estimate Statement (60-0224).
In addition, you may choose to pay for the earnings information you requested with a credit card.
31 C.F.R. Part 206 specifically authorizes us to collect credit card information. The information you provide about your credit card is voluntary. Providing payment information is only necessary if you are making payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order). If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and the Social Security Administration's (SSA) account.

Routine uses applicable to credit card information, include but are not limited to:
(1) to enable a third party or an agency to assist Social Security to effect a salary or an administrative offset or to an agent of SSA that is a consumer reporting agency for preparation of a commercial credit report in accordance with 31 U.S.C. §§ 3711, 3717 and 3718; and (2) to a consumer reporting agency or debt collection agent to aid in the collection of outstanding debts to the Federal Government.
A complete list of routine uses for credit card information is available in our System of Records Notice entitled, the Financial Transactions of SSA Accounting and Finance Offices (60-0231). The notice, additional information regarding this form, routine uses of information, and our programs and systems is available on-line 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 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for only ONE Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select ONE type of earnings statement and include the appropriate fee.

1. **Certified/Non-Certified Itemized Statement of Earnings**
   This statement includes years of self-employment or employment and the names and addresses of employers.
2. **Certified Yearly Totals of Earnings**
   This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attach the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. **Someone Else's Earnings**
   The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. **A Deceased Person's Earnings**
   You can request earnings information from the record of a deceased person if you are:
   - The legal representative of the estate;
   - A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
   - An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

   You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $115 fee for providing information for purposes unrelated to the administration of our programs.

1. **Certified or Non-Certified Itemized Statement of Earnings**
   In most instances, individuals request itemized Statements of Earnings for purposes unrelated to our programs such as a private pension plan or personal injury suit. Bulk submitters may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

   We will certify the itemized earnings information for an additional $33.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

   Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. **Certified Yearly Totals of Earnings**
   We charge $33 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable, DO NOT SEND CASH.

You may pay by credit card, check or money order.

- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

• **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to:	If using private contractor such as FedEx mail form, supporting documentation and applicable fee to:
Social Security Administration Division of Earnings and Business Services P.O. Box 33011 Baltimore, Maryland 21290-3003	**Social Security Administration** Division of Earnings and Business Services 6100 Wabash Ave. Baltimore, Maryland 21215

• **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	Certified Itemized Statement of Earnings
$115.00	$148.00

• **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $33.00. You may obtain non-certified yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	( ) - Area Code
Credit Card Number	- - -
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $33, $115, or $148 SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

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 206(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
Discovery Resource	1511 West 34th Street
	Houston, TX 77018

*I want this information released because: For information purposes pertaining to civil litigation
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
- [X] My benefit/payment amounts from _____ to _____
- [X] 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.
- [X] Complete medical records from my claims folder(s)
- [X] Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) Assessments; Questionnaires, Applications for Claims; DDS Determinations' Award or Denial Letters; SSA Form 821 & SSA Form 3368

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: _____

Form **8821**

(Rev. March 2015)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ Information about Form 8821 and its instructions is at *www.irs.gov/form8821*.

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

▶ Do not use Form 8821 to request copies of your tax returns or to authorize someone to represent you.

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone
Function
Date

1 Taxpayer information. Taxpayer must sign and date this form on line 7.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ▶ ☐

Name and address	CAF No.
	PTIN
	Telephone No.
	Fax No.
	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters

4 Specific use not recorded on Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ▶ ☐

5 Disclosure of tax information (you must check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☐

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you do not want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☐

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box is not checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ **IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.**

▶ **DO NOT SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature _____ Date _____

Print Name _____ Title (if applicable) _____

Instructions for Form 8821

(Rev. March 2015)

Tax Information Authorization

Department of the Treasury
Internal Revenue Service

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

General Instructions

Future Developments. For the latest information about developments related to Form 8821 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/form8821*.

Purpose of Form

Form 8821 authorizes any individual, corporation, firm, organization, or partnership you designate to inspect and/or receive your confidential information verbally or in writing for the type of tax and the years or periods you list on Form 8821. Form 8821 is also used to delete or revoke prior tax information authorizations. See the instructions for line 6, later.

You may file your own tax information authorization without using Form 8821, but it must include all the information that is requested on Form 8821.

Form 8821 does not authorize your appointee to speak on your behalf; to execute a request to allow disclosure of return or return information to another third party; to advocate your position with respect to federal tax laws; to execute waivers, consents, closing agreements; or represent you in any other manner before the IRS. Use Form 2848, Power of Attorney and Declaration of Representative, to authorize an individual to represent you before the IRS. The appointee may not substitute another party as your authorized designee.

Authorizations listed on prior Forms 8821 are automatically revoked unless you attach copies of your prior Forms 8821 to your new submissions.

CAUTION *Your appointee is never allowed to endorse or negotiate a taxpayer's refund check or receive a taxpayer's refund via direct deposit.*

Need a copy of tax return information? Go to irs.gov and click on "Get Transcript of Your Tax Records" under "Tools" to obtain and print a transcript of your past tax returns, or request the transcript be mailed to you. IRS transcripts of your tax return are often used instead of a copy of the actual tax return to validate income and tax filing status for mortgage applications, student and small business loan applications, and during tax preparation.

You may also request transcript information by mail by completing Form 4506-T, Request for Transcript of Tax Return, or Form 4506-TEZ, Short Form Request for Individual Tax Return Transcript.

If you want a photocopy of an original tax return, use Form 4506, Request for Copy of Tax Return. There is a fee for each return ordered, which must be paid with your request.

When a properly executed Form 8821 is on file with the IRS, your appointee can also get on-line tax information through e-Services - Online Tools for Tax Professionals at irs.gov.

Form 56. Use Form 56, Notice Concerning Fiduciary Relationship, to notify the IRS of the existence of a fiduciary relationship. A fiduciary (trustee, executor

Where To File Chart

IF you live in...	THEN use this address...	Fax number*
Alabama, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, or West Virginia	Internal Revenue Service Memphis Accounts Management Center 5333 Getwell Road, Stop 8423 Memphis, TN 38118	855-214-7519
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, or Wyoming	Internal Revenue Service 1973 N. Rulon White Blvd. MS 6737 Ogden, UT 84201	855-214-7522
All APO and FPO addresses, American Samoa, nonpermanent residents of Guam or the U.S. Virgin Islands**, Puerto Rico (or if excluding income under Internal Revenue Code section 933), a foreign country, U.S. citizens and those filing Form 2555, 2555-EZ, or 4563.	Internal Revenue Service International CAF Team 2970 Market Street MS:3-E08.123 Philadelphia, PA 19104	855-772-3156 267-941-1017 (Outside the United States)

* These numbers may change without notice. For updates, go to *www.irs.gov/form8821* and search under "Recent Developments."

**Permanent residents of Guam should use Department of Taxation, Government of Guam, P.O. Box 23607, GMF, GU 96921; permanent residents of the U.S. Virgin Islands should use V.I. Bureau of Internal Revenue, 6115 Estate Smith Bay, St. Thomas, V.I. 00802.

administrator, receiver, or guardian) stands in the position of a taxpayer and acts as the taxpayer, not as a representative. A fiduciary may authorize an individual to represent or perform certain acts on behalf of the person or entity by filing a power of attorney that names the eligible individual(s) as representative(s) for the person or entity. Because the fiduciary stands in the position of the person or entity, the fiduciary must sign the power of attorney on behalf of the person or entity.

When To File

If you are submitting Form 8821 to authorize disclosure of your confidential tax information for a purpose other than addressing or resolving a tax matter with the IRS (e.g., for income verification required by a lender), the IRS must receive the Form 8821 within 120 days of the taxpayer's signature date on the form. This 120-day requirement does not apply to a Form 8821 submitted to authorize disclosure for the purpose of assistance with a tax matter with the IRS.

Where To File

If you check the box on line 4, mail or fax Form 8821 to the IRS office handling the specific matter. Otherwise, mail or fax Form 8821 directly to the IRS address according to the *Where To File Chart*, earlier.

Taxpayer Identification Number (TIN)

A TIN is used to confirm the identity of a taxpayer and identify the taxpayer's return and return information. It is important that you furnish your correct name, social security number (SSN), individual taxpayer identification number (ITIN), and/or employer identification number (EIN).

Partnership Items

A tax matters partner is authorized to perform certain acts on behalf of an affected partnership. Rules governing the use of Form 8821 do not replace any provisions of law concerning the tax treatment of partnership items.

Appointee Address Change

If your appointee's address changes, a new Form 8821 is not required. The appointee can provide the IRS with the new information by sending written notification of the new address to the location where the Form 8821 was filed. Your appointee must sign and date the written notice of address change.

Specific Instructions

Line 1. Taxpayer Information

Individual. Enter your name, TIN, and your street address in the space provided. Do not enter your appointee's name or address information in the Taxpayer Information box. If a return is a joint return, the appointee(s) identified will only be authorized for you. Your spouse, or former spouse, must submit a separate Form 8821 to designate an appointee.

Corporation, partnership, or association. Enter the name, EIN, and business address.

Employee plan or exempt organization. Enter the name, address, and EIN or SSN of the plan sponsor/plan name, exempt organization or bond issuer. Enter the three-digit plan number when applicable. If you are the plan's trustee and you are authorizing the IRS to disclose the tax information of the plan's trust, see the instructions relating to the trust.

Trust. Enter the name, title, and address of the trustee, and the name and EIN of the trust.

Estate. Enter the name and address of the estate. If the estate does not have a separate identification number, enter the decedent's SSN or ITIN.

Line 2. Appointee

Enter your appointee's full name. Use the identical full name on all submissions and correspondence. Enter the nine-digit CAF number for each appointee. If an appointee has a CAF number for any previously filed Form 8821 or power of attorney (Form 2848), use that number. If a CAF number has not been assigned, enter "NONE," and the IRS will issue one directly to your appointee. The IRS does not assign CAF numbers to requests for employee plans and exempt organizations.

If you want to name more than one appointee, check the box on line 2, and attach a list of appointees to Form 8821. Provide the address, and requested numbers for each appointee named.

If Form 8821 is being submitted for the sole purpose of updating the appointee's address or telephone/fax number, check the applicable box.

Line 3. Tax Information

Enter the type of tax information, the tax form number, the years or periods, and the specific matter. For example, you may list "Income, 1040" for calendar year "2014" and "Excise, 720" for "2014" (this covers all quarters in 2014).

For multiple years or a series of inclusive periods, including quarterly periods, you may enter, for example, "2012 thru 2014" or "2nd 2013-3rd 2014." For fiscal years, enter the ending year and month, using the YYYYMM format.

Do not use a general reference such as "All years," "All periods," or "All taxes." Any tax information authorization with a general reference will be returned.

You may list the current year/period and any tax years or periods that have already ended as of the date you sign the tax information authorization. You may also list future tax years or periods. However, **the IRS will not record on the CAF system future tax years or periods listed that exceed 3 years from December 31 of the year that the IRS receives the tax information authorization.**

You must enter the description of the matter, the tax form number, and the future year(s) or period(s). If the matter relates to estate tax, enter the date of the decedent's death instead of the year or period. If the matter relates to an employee plan, include the plan number in the description of the matter.

If you appoint someone only with respect to a penalty and interest due on that penalty, enter "civil penalty" in

column (a), and if applicable, enter the tax year(s) for the penalty. Enter "NA" (not applicable) in column (b). You do not have to enter the specific penalty.

If the taxpayer is subject to penalties related to an individual retirement account (IRA) enter "IRA civil penalty" in column (a).

Note. If Form W-2 is listed on line 3, then the appointee is entitled to receive taxpayer notices regarding any civil penalties and payments related to that Form W-2. A Form 8821 that lists a particular tax return will also entitle the appointee to receive the taxpayer notices regarding any return-related civil penalties and payments. For example, if Form 1040 is listed, the appointee is entitled to receive taxpayer notices regarding the section 5000A individual shared responsibility payment. Specific reference to those penalties and payments is not required. However, any civil penalty or healthcare-related payment that is not return-related, such as the section 4980H employer shared responsibility payment, the annual fee for branded prescription drug sales under section 9008 of the Affordable Care Act (ACA), or health insurance provider fee under section 9010 of the ACA, is not covered by the Form 8821 unless column (a) references "civil penalties" or the name of a specific penalty or payment.

Column (d). Enter any specific information you want the IRS to provide. Examples of column (d) information: lien information, balance due amount, a specific tax schedule, section 4980H employer shared responsibility payment information, or a tax liability.

Enter "not applicable" in column (d) if you are not limiting your appointee's authority to inspect and/or receive all confidential tax information described in columns (a), (b), and (c).

For requests regarding Form 8802, Application for United States Residency Certification, enter "Form 8802" in column (d) and check the specific box on line 4. Also, enter the appointee's information as instructed on Form 8802.

Line 4. Specific Use Not Recorded on CAF

Generally, the IRS records all tax information authorizations on the CAF system. However, authorizations relating to certain issues are not recorded. Check the box on line 4 if Form 8821 is being submitted for any of the following reasons.

1. Requests to disclose information to loan companies or educational institutions.
2. Requests to disclose information to federal or state agency investigators for background checks.
3. Requests for information regarding the following forms:

a. Form SS-4, Application for Employer Identification Number,

b. Form W-2 Series,

c. Form W-4, Employee's Withholding Allowance Certificate,

d. Form W-7, Application for IRS Individual Taxpayer Identification Number,

e. Form 843, Claim for Refund and Request for Abatement,

f. Form 966, Corporate Dissolution or Liquidation,

g. Form 1096, Annual Summary and Transmittal of U.S. Information Returns,

h. Form 1098, Mortgage Interest Statement,

i. Form 1099 Series,

j. Form 1128, Application to Adopt, Change or Retain a Tax Year,

k. Form 2553, Election by a Small Business Corporation, or

l. Form 4361, Application for Exemption From Self-Employment Tax for Use by Ministers, Members of Religious Orders and Christian Science Practitioners.

If you check the box on line 4, your appointee should mail or fax Form 8821 to the IRS office handling the matter. Otherwise, your appointee should bring a copy of Form 8821 to each appointment to inspect or receive information. A specific-use tax information authorization will not revoke any prior tax information authorizations.

Line 5. Disclosure of Tax Information

The IRS will send copies of notices and communications to no more than two appointees. If you check the box for line 5a and the IRS has a prior Form 2848 or 8821 from you that authorized other appointees to receive copies of notices and communications for the same tax and tax years, the IRS will stop sending notices and communications to the appointees designated on the prior Form 2848 or 8821.

Line 6. Retention/Revocation of Prior Tax Information Authorizations

If the line 4 box is checked, skip line 6. If line 4 is not checked, the IRS will automatically revoke all prior tax information authorizations on file unless you instruct otherwise. If you do not want a prior tax information authorization submission to be revoked, you must attach a copy of the tax information authorization that you want to retain and check the line 6 box.

Revocation request. If you want to revoke a prior tax information authorization without submitting a new authorization, write "REVOKE" across the top of the particular authorization that you want to revoke. Provide a current taxpayer signature and date under the original signature that was provided on line 7.

If you do not have a copy of the tax information authorization you want to revoke, send a notification to the IRS. In the notification:

1. State that the authority of the appointee is revoked,
2. List the name and address of each appointee whose authority is being revoked,
3. List the tax matters and tax periods, and
4. Sign and date the notification.

If you are completely revoking the authority of the appointee, state "revoke all years/periods" instead of listing the specific tax matters, years, or periods.

To revoke a specific use tax information authorization, send the tax information authorization or notification of revocation to the IRS office handling your case, using the above instructions.

Line 7. Signature of Taxpayer

Individual. You must sign and date the authorization. If a joint return has been filed, your spouse must execute his or her own authorization on a separate Form 8821 to designate an appointee.

Corporation. Generally, Form 8821 can be signed by:

1. An officer having authority under applicable state law to bind the corporation,
2. Any person designated by the board of directors or other governing body,
3. Any officer or employee on written request by any principal officer and attested to by the secretary or other officer, and
4. Any other person authorized to access information under section 6103(e)(1)(D), except for a person described in section 6103(e)(1)(D)(iii) (bona fide shareholders of record owning 1% or more of the outstanding stock of the corporation).

Partnership. Generally, Form 8821 can be signed by any person who was a member of the partnership during any part of the tax period covered by Form 8821. See *Partnership Items*, earlier. If the Form 8821 covers more than one tax year or tax period, the person must have been a member of the partnership for all or part of each tax year or period covered by Form 8821.

Employee plan. If the plan is listed as the taxpayer on line 1, a duly authorized individual having authority to bind the taxpayer must sign and that individual's exact title must be entered.

Trust. A trustee having the authority to bind the trust must sign with the title of trustee entered. If the trust has not previously submitted a completed Form 56, Notice Concerning Fiduciary Relationship, identifying the current trustee, the trust must submit a Form 56 to identify the current trustee.

Estate. An executor having the authority to bind the estate must sign. A Form 56 should be filed to identify the executor. If there is more than one executor, only one executor having the authority to bind the estate is required to sign. See Regulations section 601.503(d).

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.

Privacy Act and Paperwork Reduction Act Notice

We ask for the information on this form to carry out the Internal Revenue laws of the United States. Form 8821 authorizes the IRS to disclose your confidential tax information to the person you appoint. This form is provided for your convenience and its use is voluntary. The information is used by the IRS to determine what confidential tax information your appointee can inspect and/or receive. Section 6103(c) and its regulations require you to provide this information if you want to designate an appointee to inspect and/or receive your confidential tax information. Under section 6109, you must disclose your identification number. If you do not provide all the information requested on this form, we may not be able to honor the authorization. Providing false or fraudulent information may subject you to penalties.

We may disclose this information to the Department of Justice for civil or criminal litigation, and to 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.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is: **Recordkeeping,** 6 min.; **Learning about the law or the form,** 12 min.; **Preparing the form,** 24 min.; **Copying 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 8821 simpler, we would be happy to hear from you. You can send your comments from *www.irs.gov/formspubs*. Click on "More Information" and then on "Give us feedback." Or you can send your comments to the Internal Revenue Service, Tax Forms and Publications, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. **Do not** send Form 8821 to this address. Instead, see the *Where To File Chart*, earlier.

AUTHORIZATION TO DISCLOSE WORKERS' COMEPNSATION INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to the agents or designees of the law firm of:

- Shook, Hardy & Bacon LLP, 600 Travis Street, Suite 3400, Houston, Texas 77002
- (Plaintiff Attorney)_____
- (Local Counsel)_____
- Discovery Resource, 1511 West 34th Street, Houston, Texas 77018

Any and all records containing Workers' Compensation information, regarding _____, whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of Shook, Hardy & Bacon LLP, _____, _____, and/or Discovery Resource 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; al 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 disclosure full and complete protected medical information spanning the time period of _____ (DOB) to present.

Because this litigation is ongoing, it is imperative that you preserve the original workers' compensation records. Please take all steps that are necessary to preserve the workers' compensation records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Shook, Hardy & Bacon LLP, (Pltf. Atty.)_____, (Local Counsel)_____, and/or Discovery Resource, except to the extent that the entity has already relied upon this Authorization to disclose protected heath information (PHI).**
- **The individual signing this authorization understand 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 will no longer be protected by 45 CFR Section 164, Subpart E.**

I have real this Authorization and understand that it will permit the entity identified above to disclose PHI to Shook, hardy & Bacon LLP, _(Pltf. Atty)_____, _(Local Counsel)_____, and/or to Discovery Resource.

_____
Signature

_____
Print Name

_____
Date

_____
Former/Alias/Maiden Name

_____
Date of Birth

_____
Social Security Number

_____
Address

_____
City/State/Zip Code

HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF PSYCHOLOGICAL RECORDS/PSYCHOTHERAPY NOTES
PURSUANT TO 45 CFR 164.508(a)(2)

NOTE: SIGN ONLY IF CLAIMING PSYCHOLOGICAL DAMAGES PER SECTION VII(7) AND/OR XII(3) OF THE PFS

Name or specific identification of the provider, person(s), or class of persons, authorized to make the requested disclosure:

_____

_____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ _____

I authorize the disclosure of all psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition, including substance abuse (including drug and alcohol information) for the purpose of review and evaluation in connection with a legal claim. I expressly request that 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, documents, correspondence, test results, statements, questionnaires/histories, therapy notes, office and doctor's handwritten notes, records received by other physicians, pharmacy and prescription records and billing records.

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

I authorize you to release the protected health information to:

Discovery Resource
1511 West 34th Street
Houston, Texas 77018
(713) 223-3300

The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.

I acknowledge the right to revoke this authorization by writing to Shook Hardy & Bacon, LLP, 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 acknowledge the right to inspect the material to be released.

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 expires two years from the date below.

Signature: _____ Date: _____
Relationship to the person who is the subject of the records:
Self: x Other: _____
Describe authority: _____

AUTHORIZATION FORM
FOR THE RELEASE OF ADVERSE EVENT REPORTS
PURSUANT TO 21 C.F.R. § 20.63

I, _____, hereby authorize and consent to the release of any and all Adverse Event reports relating to my medical condition(s) and care at issue, and with my name unredacted, including FDA Medical Device Reports and manufacturer-generated Issue Reports, to my counsel of record as indicated below:

NAME: _____

ADDRESS: _____

PHONE: _____

_____ Date:
Signature of Individual or Representative

_____
Printed Name of Representative and Relationship to Individual (if applicable)

_____
Description of Representative's Authority (if applicable)