

**HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EMPLOYMENT RECORDS
PURSUANT TO 45 C.F.R. § 164.508**

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

Employee Name: _____ A/K/A _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize disclosure of all protected employment or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to present including the following:

- All employment information, records and reports, including all tax records, employee reviews, and payroll information.
- All medical information, records and reports, including disability employment applications and disability records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)

Yes, disclose HIV/AIDS information No, do NOT disclose HIV/AIDS information
 Yes, disclose alcohol/substance abuse information No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to:

Defendant(s) Counsel:

- | Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Post Office Box 14167, Jackson, MS 39236 (Counsel for Cardinal Health 409, Inc. n/k/a Catalent Pharma Solutions, Inc.) and Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP, One Oxford Center, 38th Floor, Pittsburgh, PA 15219 (Counsel for the Mylan Defendants).
- | Ulmer & Berne, LLP, 600 Vine Street, Suite 2800, Cincinnati, OH 45202-2409 (Counsel for the Barr Defendants).
- | Duane Morris, LLP, 30 South 17th Street, Philadelphia, PA, 19103-4196 (Counsel for the Ranbaxy Defendants).

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

I acknowledge the right to revoke this authorization by writing to the above noted counsel at the above 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 C.F.R. § 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 person who is the subject of the records:

Self: _____ Other: _____
Describe Authority