_____
Full Name

_____
Social Security Number

_____
Date of Birth

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS

In Compliance With the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

To:

_____
Name of Entity

_____
Address

_____
City, State, Zip Code

You are hereby authorized to release my entire medical records file to the Records Requester(s) listed below. This release authorizes you to furnish copies of any information, including but not limited to the medical records, psychotherapy notes, and clinical information concerning the assessment, evaluation, treatment, and/or hospitalization related to mental health or psychiatric illnesses or conditions.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. You are hereby authorized to release these medical records to the following Records Requester(s) for their use in the above-entitled litigation. The defendant has agreed to pay reasonable charges to supply copies of such records. Copies of any records obtained will be provided, per agreement, to my legal counsel. You should provide all documents and information to:

Records Requester(s)

1. Waller Lansden Dortch & Davis, 511 Union Street, Suite 2700 Nashville, Tennessee, 37219 (counsel for Merck & Co., Inc.), or their designated agent(s) ("Receiving Party").

I understand that the health information being disclosed by these psychotherapy notes may include information relating to and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases and drug and alcohol disorders.

I understand that this authorization pertains to the civil litigation referenced above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. I understand that this authorization remains in full force and effect until such expiration or revocation, as more fully described below, and further authorizes you to release to the Records Requester(s) any additional records created or obtained by you after the date of execution of this authorization. I understand and intend that you may rely on this authorization in all respects unless you have previously been advised by me in writing to the contrary.

I understand that I may revoke this authorization at any time by providing you a written revocation, but that my revocation will be effective only to the extent that the information has not already been released. I further 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 this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

I understand that any documents or information released by you could potentially be re-disclosed by the aforementioned Records Requester(s) and that any information re-disclosed by that party is not subject to this authorization and may not be subject to HIPAA, the Federal Regulations promulgated under the authority of HIPAA, and more specifically, the requirements imposed by 45 C.F.R. § 164.508. I expressly permit the Records Requester(s) to re-disclose my medical records file for purposes limited to this civil litigation matter or related to the defendant's legal obligations to provide information to the Food and Drug Administration.

This authorization shall not be valid unless the Records Requester(s) named above has executed the acknowledgment at the bottom of this authorization.

This authorization is executed and served in compliance with HIPAA, the Federal Regulations promulgated thereunder, and more specifically, 45 C.F.R. § 164.508, all of which govern the requirements for the release of private health information.

Name of Patient	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's authority to act for Patient.

Subscribed and sworn to before me this ____ day of _____, 200_.

_____
Notary Public

My Commission Expires:

_____

ACKNOWLEDGMENT

The undersigned, as the Records Requester(s) named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records and information from the person or entity to whom it is addressed. The attorney for or the person named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requester at a reasonable cost.

Records Requester's Signature: Peter Hollaway
partner, Waller Lansden Dortch & Davis, LLP