This Order hereby supersedes and replaces all prior Notices and Orders Regarding Service of Plaintiff's Fact Sheets, Records Authorizations, and Applications for Extension of Service Dates filed on 12/1//2021, 11/16/12, 2/14/14, 12/15/16, 7/30/18, 3/15/2019, 6/30/2022, 1/19/2023, 8/28/2023, 3/17/2025

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Attorneys for Defendants,
Ethicon, Inc. and Johnson & Johnson

FILED
SEP 16 2025
GREGG A. PADOVANO, J.S.C.

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION - BERGEN COUNTY

IN RE PELVIC MESH/GYNECARE LITIGATION,

MASTER DOCKET NO.
BER-L-11575-14

CIVIL ACTION
In re Pelvic Mesh/Gynecare Litigation
Case No. 291

UPDATED AND AMENDED NOTICE AND ORDER REGARDING SERVICE OF PLAINTIFF'S FACT SHEETS, REQUIRED RECORDS AUTHORIZATIONS AND APPLICATIONS FOR EXTENSION OF SERVICE DATES (UPDATED September 2025)

TO: All Counsel of Record

PLEASE TAKE NOTICE that, in accordance with Case Management Order No. 5, and in order to ensure uniformity in the service of Plaintiffs' Fact Sheets ("PFS"), the following protocols have been put into place regarding the service of PFSs and applications for extension of service dates. To the extent any of the below protocols deviates from previously entered orders, the below procedures are to be followed beginning immediately upon the entry of this Order for all cases subject to this MCL.

1. **SERVICE OF PFSs**

   a. PFSs are not to be served prior to service of the plaintiff's Complaint. In the event that the PFS is served before the Complaint, Defendants will calculate the due date of the Defendants' Fact Sheet ("DFS") from the date of service of the Complaint.

   b. PFSs are to be served on a rolling basis and are not to be accumulated for mass service. Any one firm shall serve no more than two (2) PFSs in one day to avoid both the imposition of an unreasonable burden on Defendants to process and serve DFS responses within the time contemplated by governing CMO No. 5, and the contravention of this Court's directive for Plaintiffs to avoid such unnecessary burdens.

   c. PFSs and supporting documents for multiple plaintiffs are not to be served electronically in a combined file. While size limitations may require scanned documents to be served in multiple separate files, any electronic file (e.g. pdf) of a PFS response or supporting documents must contain information as to a single plaintiff. For example, a single pdf file may not contain PFS responses or supporting documents for more than a single plaintiff.

d. PFSs with the most updated authorizations in the form attached hereto as Exhibit A are to be served upon Defendants via email addressed to the following individuals:

   i. Butler Snow – njpfs@butlersnow.com

   ii. Riker Danzig - RikerPelvicPFS@riker.com

Service to any subset of the above individuals, service to Defense liaison counsel, or service to other employees of the law firms identified above, is not adequate and may result in motion practice seeking, among other things, dismissal of the complaint.

e. Plaintiffs' counsel may also serve PFSs via regular mail. In the event that counsel chooses this method, the PFSs should be sent to:

Debra Gantert Francesca Henry Riker Danzig LLP 7 Giralda Farms, Ste 250 Madison, NJ 07940	Tracey Bates Butler Snow LLP Suite 1400 1020 Highland Colony Pkwy Ridgeland, MS 39157

Service via regular mail must be supplemented with service via email to the recipients identified in Section 1(d).

f. To accommodate the size of the files, Plaintiffs' counsel may serve plaintiffs' medical records and authorizations separately via regular mail, however it is preferred to avoid hard copy documents when possible. These records are to be sent to Debra Gantert, Francesca Henry and Tracey Bates as indicated in Section 1(e).

g. PLEASE TAKE NOTICE THAT THE PROCEDURE CHANGE REGARDING RECORDS COLLECTION SET FORTH INITIALLY at Paragraph 5 OF THE JANUARY 19, 2023, ORDER REMAINS IN EFFECT AND IS REITERATED BELOW at Paragraph 5. If plaintiffs choose to opt-out of records collection by the medical records vendor, which is not preferable, notice must be sent via email and regular mail to Debra Gantert, Francesca Henry and Tracey Bates as indicated in Section 1(e) & (f).

2. **APPLICATIONS FOR EXTENSIONS**

   a. Applications to Defendants for extension of the PFS service date are to be sent via email to the following individuals:

      i. Butler Snow – njpfs@butlersnow.com

      ii. Riker Danzig - RikerPelvicPFS@riker.com

   b. Each application must include the name and docket number of the plaintiff at issue and the length of time needed to complete the PFS.

   c. Extension requests are expected to be the exception, and not routine.

3. **COMMUNICATIONS REGARDING DEFICIENCIES IN PFS RESPONSES**

a. All Communications relating to Deficiencies in PFS responses, including, but not limited to supplemental responses, additional responsive information, objections to claims of deficiencies, or extension related requests, are to be sent via email to the following individuals:

   i. Butler Snow – njpfs@butlersnow.com

   ii. Riker Danzig - RikerPelvicPFS@riker.com

b. Each communications must include the name and docket number of the plaintiff.

c. **Communications regarding deficiencies or extension requests to any subset of the above individuals, to Defense liaison counsel, or to other employees of the law firms identified above, is not adequate.**

4. **GENERAL OBLIGATIONS REGARDING PFS RESPONSES**

   a. PFS forms shall be completed with full and correct information to the best of plaintiff's knowledge. A completed Fact Sheet shall be considered interrogatory answers and as responses to requests for production pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure. Such responses require the execution of a **dated** PFS Certification **signed by** the Plaintiff(s). Electronic signatures are not compliant. Failure to provide an answer or respond, or failure to properly certify responses, may lead to dismissal under Rule 4:23-5(a) and related protocols established by this Court.

b. The plaintiff certification requirement set forth in paragraph (a), above, extends to required Certifications that there has been no change to the PFS or medical status that may be required from time to time by Court order, and shall not be required for routine supplements and amendments by counsel.

c. All parties are to comply fully with this protocol.

5. **CHANGE TO RECORDS COLLECTION VENDOR AND GENERAL OBLIGATIONS REGARDING RECORDS AUTHORIZATIONS**

a. For all cases filed or otherwise made part of this MCL after December 2, 2021, and the entry of the Amendment to CMO 3 accompanying the December 2, 2021 predecessor order, plaintiffs are to provide fully-executed (but undated) copies of each of the updated authorizations appended to this Order as Schedule A. Prior forms of authorization appended to prior orders such as CMO No. 5 are now obsolete.[1] Plaintiff

[1] Paragraphs 7 and 8 of CMO 3 entered on 2012 remain in effect but also now include vendor LMI: If a plaintiff's counsel does not wish to enter into the agreement with *Marker* or with *LMI*, plaintiff's counsel will nevertheless provide executed authorizations with its Plaintiff's Fact Sheets which are fully completed to the best of plaintiffs' and plaintiffs' counsel's ability and knowledge with the names of plaintiffs' treaters, complete and correct addresses for the treating physicians and/or facility, and are generally consistent with the time frame of twenty (20) years prior to the date of plaintiff's initial mesh implant surgery for every physician requested to be identified in the Plaintiffs' Fact Sheet. If plaintiff's counsel does not believe the 20 year time frame is appropriate based on the specific circumstances of the Plaintiff's case, the parties are to meet and confer. If the matter cannot be resolved, the parties are to request a telephonic conference with the Court and in advance of that conference are to submit their respective positions in writing to the Court. (¶ 7) If defense counsel is seeking medical records pertaining to abortion procedures which occurred more than twenty (20) years prior to the date of plaintiff's initial mesh implant surgery,

is required to execute *all* of the form authorizations with one exception; if the plaintiff provides with the PFS response a signed certification that no claims are being made for lost wages, then the plaintiff need not execute the IRS forms 4506 and 8821.

b. For all cases filed or otherwise made part of this MCL as of December 2, 2021 and Amended CMO 3, Records Collection will be conducted by LMI (not the Marker Group). For all cases filed prior to December 2, 2021, records will continue to be collected by the Marker Group, unless otherwise agreed between the parties to a particular case.

c. All parties are to comply fully with this protocol and those of Amended CMO 3.

Last updated: September 16 2025

So Ordered:

Honorable Gregg A. Padovano, J.S.C

4938-7061-5655, v. 1

defense counsel must provide support for their position to plaintiffs' counsel and the Court that these abortions are relevant to, impacted, or contributed to the injuries that plaintiff now attributes to the mesh which is the subject matter of her lawsuit. (¶8).

Exhibit A

IN RE: PELVIC MESH / GYNECARE LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: BERGEN COUNTY CASE NO. 291 MASTER CASE NO. BER-L- 011575-14

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses within a reasonable time if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure and as responses to requests for production pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure. The questions and requests for production contained in the Fact Sheet are non-objectionable and shall be answered without objection.

In filling out this form, please use the following definitions:

"Healthcare provider" means any doctor, physician, surgeon, pharmacist, hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

"You" or "Your" refer to the person who received a pelvic mesh product manufactured by Ethicon, Inc. and who is identified in Question I. 1 (d) below.

"Gynecare Mesh Product(s)" refers to any pelvic mesh product manufactured by Ethicon, Inc. that was implanted in you.

To the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

I. BACKGROUND INFORMATION

1. Please state:

   a. Case caption:______________________________

   b. Docket number: ______________________________

   c. Court in which case was originally filed: ______________________________

   d. Full name of the person who received the Gynecare Mesh Product, including maiden name:

      ____

   e. Full name and address of the person completing this form, if different from the person listed in 1 (a) above, and the relationship of the person completing this form to the person listed in 1 (a) above:

      ____

      ____

   f. If completing this form in a representative capacity, please state whether you were appointed by a court, which court appointed you, and the date of your appointment: ______________________________

      ____

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

      ____

   h. The name and address of the attorney representing you in this case: ____________

      ____

2. Your Social Security Number: ______________________________

3. Your date and place of birth: ______________________________

4. Your current residence address:______________________________

   ____

5. Identify all individuals who currently live or have lived with you at your current address, their relationship to you, and the dates of residence. ______________________________

____

____

6. If you have lived at your current address for less than 10 years, provide each of your prior residence addresses from 2000 to the present:

Prior Address	Dates you Lived At This Address	People Who Lived With You At This Address/Relationship To You

7. Have you ever been married? **Yes** ___ **No** ____

If **Yes** provide the names and addresses of each spouse and the inclusive dates of your marriage to each person.____

____

____

8. Do you have children? **Yes** ___ **No** __

If **Yes**, please provide the following information with respect to each child:

Full Name of Child	Date of Birth	Home Address (if different from yours)	Whether Biological/Adopted	Type of Deliver: Vaginal/C-Section

9. Have you had any pregnancies other than those that resulted in the births of your children identified above?

Yes ___ **No** ____ If **Yes**, provide the date and the outcome of each pregnancy:

____

____

10. Identify all secondary and post-secondary schools you attended, starting with high school and please provide the following information with respect to each:

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

11. Please provide the following information for your employment history over the past 10 years:

Employer Name	Addresses	Job Title/ Description of Duties	Dates of Employment	Salary/Rate of Pay

12. Have you ever served in any branch of the military? **Yes** ________ **No** ________

If **Yes**, please provide the following information:

a. Branch and dates of service:; dates of your service, rank upon discharge and the type of discharge you received: ____

____

b. Were you discharged from the military at any time for any reason relating to your medical, physical, or psychiatric condition? **Yes** ___________ **No** ________

If **Yes**, state what that condition was: ____

13. To the best of your knowledge, as an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? **Yes** __________ **No** ________

If **Yes**, please set forth where, when and the felony and/or crime:

____

____

II. CLAIM INFORMATION

1) Do you claim to have been implanted with a pelvic mesh product manufactured by Ethicon, Inc. (hereafter referred to in these questions as the "Gynecare Mesh Product(s)")? **Yes** ________ **No** ________

If **Yes**:

a) Identify the Gynecare Mesh Product(s) that were implanted in you and provide the product code and lot number specific to that product, if known:

____

b) Please give the date that the Gynecare Mesh Product(s) was implanted in you:

____

2) Please identify the type of surgery that you received:

a) TVT: ____
b) TVT-O:_____
c) TVT-Secur:_____
d) Prolift Total: ______
e) Prolift Anterior:_____
f) Prolift Posterior:______
g) TVT Exact

h) TVT Abbrevo
i) Prolift + M Total: ______
j) Prolift + M Anterior:_____
k) Prolift + M Posterior:______
l) Prosima
m) Other: __________

3) Identify to the best of your knowledge the medical condition(s) and symptoms you were experiencing, that led to the implantation of the Gynecare Mesh Product(s): ___________

____

____

____

4) a) Give the name and address of the doctor who implanted the Gynecare Mesh Product(s):

____

____

b) Are you currently being treated by the surgeon identified above?

Yes _____ **No** _____

If **No,** what was the date of your last visit or consultation with the surgeon?

____

5) To the best of your knowledge, were there any concurrent surgical procedures performed during the surgery in which the Gynecare Mesh Products were utilized? If so please identify the concurrent procedure(s) and the doctor(s) who performed them:

____

____

6) Give the name and address of the hospital or other healthcare facility where the Gynecare Mesh Product(s) was implanted: ______________________________

____

7) Prior to implantation, did you receive any **written or verbal** information or instructions regarding the Gynecare Mesh Product(s), including any risks or complications that might be associated with the use of the product(s)? **Yes** ________ **No** ________

If **Yes:**

a) Provide the date you received the information or instructions: ________________

b) Identify by name and address the person(s) who provided the information or instructions: ____

____

c) If you have copies of the written information or instructions you received, please attach copies to your response.

8) To the best of your knowledge, was the Gynecare Mesh Product(s) that was implanted in you ever removed, in whole or in part?

Yes ________ **No** ________ **I Don't Know** ___________

If **Yes**:

a) On what date, where and by whom (doctor) was the Gynecare Mesh Product(s), or any portion of it, removed? ____

____

b) Explain why you consented to have the Gynecare Mesh Product(s), or any portion of it, removed?____

____

____

c) To the best of your knowledge, does any medical treater, physician or anybody else on your behalf have possession of any portion of the Gynecare Mesh Product(s) that was previously implanted in you and removed?

____

____

9) To the best of your knowledge, if all or part of the Gynecare Mesh Product(s) remain implanted in you:

Has any doctor recommended removal of the Gynecare Mesh Product(s)?

Yes ____ **No** ____

If **Yes,** Identify by name and address the doctor who recommended removal and state your understanding of why the doctor recommended removal:

____

____

10) Do you claim that you suffered bodily injuries as a result of the Gynecare Mesh Product(s)?

Yes ________ **No** ________

If Yes:

a) Describe the bodily injuries, conditions and/or symptoms that you claim resulted from the Gynecare Mesh Product(s)?

____

____

____

____

b) When is the first time you experienced bodily injuries, conditions and/or symptoms you have listed above that you now relate to the Gynecare Mesh Product(s)?

____

____

____

____

c) For each bodily injury, condition and/or symptom you now claim to have experienced relating to the Gynecare Mesh Product(s), please state approximately when you first saw a health care provider for each of those bodily injuries, name of provider and diagnosis, if any, provided:

____

____

____

d) Are you currently experiencing symptoms that you relate to your claimed bodily injuries?

Yes ________ **No** ________

If **Yes**, please describe your current symptoms in detail

____

____

____

____

e) Are you currently seeing, or have you ever seen a doctor or healthcare provider for any of the bodily injuries, conditions and/or symptoms listed above?

Yes ________ **No** ________

If **Yes,** please list all doctors you have seen for treatment of any of the bodily injuries you have listed above.

Provider Name and Address	Condition Treated	Approximate Date of Treatment

f) Were you hospitalized at any time for the bodily injuries, conditions and/or symptoms you listed above?

Yes ________ **No** ________ If **Yes**, please provide the following:

Hospital Name and Address	Condition Treated	Approximate Date of Treatment

11) To the best of your knowledge, have you been diagnosed with the following:

a) Vaginal Prolapse: Yes _____ No _____

b) Uterine Prolapse: Yes ____ No _____

c) Rectocele: Yes ____ No _____

d) Cystocele: Yes ____ No _____

d) Enterocele: Yes ____ No _____

e) Urinary incontinence: Yes ____ No _____

f) Fecal incontinence: Yes ____ No _____

g) Urethral Hypermobility: Yes ____ No _____

h) Interstitial Cystitis: Yes ____ No _____

If **Yes**, to (a)-(h) above identify the doctor who communicated the diagnosis, the date of the diagnosis, and the course of treatment recommended:

____

____

____

12) Are you making a claim for lost wages or lost earning capacity?

Yes _____ **No** _____ If **Yes**, please answer the following:

a) State the annual gross income you derived from your employment for each year, beginning five years prior to your surgery until the present:

____

____

____

13) Are you making a claim for lost out-of-pocket expenses?

Yes ________ **No** ________If **Yes**, please identify and itemize all out-of-pocket expenses you have incurred:____

____

____

14) Are you claiming mental and/or emotional damages?

Yes _____ **No** _____ If **Yes**, what mental and/or emotional damages do you claim and what do you attribute them to?

____

____

If you are claiming mental and/or emotional damages, provide the following information for each provider (including but not limited to primary care physicians, psychiatrist, psychologists, therapists, and/or counselors) from whom you have sought treatment for your psychological, psychiatric or emotional conditions at any time:

Name	Address	Condition treated	Dates treated	Medications Prescribed

15) Has anyone filed a loss of consortium claim in connection with your lawsuit regarding the Gynecare Mesh Product(s)?

Yes ________ **No** ________

If **Yes:** Identify by name and address the person who filed the loss of consortium claim, and state the relationship of that person to you.: ________________________________

____

16) Have you or anyone acting on your behalf, other than your attorneys, had any communication, oral or written, with any of the defendants or their representatives?

Yes ________ **No** ________ **I Don't Know**______

If **Yes**, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:

____

____

____

III. MEDICAL BACKGROUND

1) Provide your current age: ________ Height __________ Weight __________

2) At the time you received the Gynecare Mesh Product(s), please state:

Your age __________ Your approximate weight ________

3) In chronological order, list any and all surgeries or hospitalizations you had **BEFORE** implantation of the Gynecare Mesh Product(s) for treatment of a gynecological, urological, abdominal and/or colo-rectal condition, excluding child births. Identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date	Description/ Reason for Surgery or Hospitalization	Doctor or Healthcare Provider Involved (including address)

[Attach additional sheets as necessary to provide the same information for any and all surgeries leading up to implantation of the Gynecare Mesh Product(s)]

4) In chronological order, list any and all surgeries or hospitalizations you had **AFTER** the implantation of the Gynecare Mesh Product(s) for treatment of a gynecological, urological, abdominal, colo-rectal and/or mesh-related condition, excluding child births. Identifying by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date	Description of Surgery/ Hospitalization	Doctor or Healthcare Provider Involved (including Address)

5) To the extent not already provided in the charts above, provide the name, address, and telephone number of any internal or family doctor, surgeon or hospital from which you have received medical advice and/or treatment for the past **10 years**:

Name and Specialty	Address	Approximate Date/ Years of Visits

6) To the best of your knowledge, have you ever been diagnosed by a doctor or another health care provider with any of the following:

Condition	Yes	No
Bleeding or clotting disorders		
Cancer		
Chronic obstructive pulmonary disease/COPD/chronic lung disease/Chronic coughing		
Complications related to childbirth		
Crohn's Disease, Irritable Bowel Syndrome, Ulcerative Colitis, Chronic Diarrhea or disease of the gut, intestines, or bowel		
Connective Tissue Disorder		
Diabetes		
Diverticulitis		
Fistula		
Hernia		
Malnutrition		
Obesity		
Pelvic Tumors or Fibroids		
Peripheral vascular disease or peripheral arterial disease		
Psychological/Mental/Emotional Conditions		
Recurrent constipation		

7) For each condition for which you answered **Yes** in the previous chart, or otherwise identified above, please provide the information requested below (attach additional sheets as needed):

Condition You Experienced	Date of Onset	Medication/ Treatment	Treating Physician	Current Status of Condition

8) Have you experienced menopause? **Yes** __________ **No** _________

If **Yes**, at what age did it begin? ______________________

9) Have you undergone vaginal estrogen therapy, hormone therapy, or systemic estrogen replacement therapy (ERT)? **Yes** _________ **No** _________

If Yes,

a) Were you receiving vaginal estrogen therapy, hormone therapy, or systemic estrogen replacement therapy at the time of your implantation surgery?

Yes ________ **No** ________

b) Please provide the type of therapy you received, date(s) of the therapy, and the name and address of the healthcare provider providing the therapy.

____

____

10) Have you received a hysterectomy? If so please state the doctors' name, city and state and date.

____

____

11) Do you now or have you ever smoked tobacco products? **Yes** __________ **No** ________

If **Yes**:

a) Provide the dates you smoked?

____

b) How much do/did you smoke?

____

12) Other than the implantation of the Gynecare Mesh Product(s) that are the subject of your lawsuit, have you had implanted inside of your body any other medical product of any kind, whether a mesh product or other device? **Yes** ______ **No** ________

If **Yes**, please provide the following information:

a) Product Name: ____

b) Date of Procedure Placing it and name and address of Doctor who placed it:

____

c) Condition sought to be treated through placement of the device :

____

d) Any complications you encountered with the medical product or procedure :

____

e) Does that product remain implanted inside of you today? **Yes** ______ **No** ______

13) List each prescription medication you have taken **for more than 3 months at a time, within the last 3 years prior to the implantation of the Gynecare Mesh Product until the present,** giving the name and address of the pharmacy where you received/filled the medication, the reason you took the medication, and the approximate dates of use.

Medication and Dosage	**Pharmacy (Name and Address)**	**Reason for Taking Medication**	**Approximate**

IV. INSURANCE INFORMATION

1) Provide the following information, to the best of your knowledge, for any past or present medical insurance coverage within the last 10 years:

Insurance Company (Name and Address)	Policy Number	Name of Policy Holder/ Insured (If different than you)	Approx.. Dates of Coverage

2) Are you receiving Medicare benefits due to age, disability, conditions or any other reason or basis?

1) Yes ________ No ___________

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.]

3) Has Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last (10) years?

Yes ________ **No** ________ If **Yes**, please specify the following:

a) Medicare/Medicaid:________________________________

b) Address:____

c) Dates of Service:____

[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.]

4) Have you ever been denied life insurance for reasons relating to your health?

Yes ________ **No** ________ If **Yes**, please state when the denial occurred, the name of the life insurance company, and the company's reason for denial: ________________

____

5) Have you personally paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by a Gynecare Mesh Product and for which you seek recovery in the action you have filed?

Yes ______ **No** ______

If **"Yes,"** state the total amount of such expenses at this time: $________

6) Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of a Gynecare Mesh Product and for which you seek recovery in the action you have filed?

Yes ______ **No** ______

2) **If** "Yes," **state the total amount of such expenses at this time: $________**

V. PRIOR CLAIM INFORMATION

1) Have you filed a lawsuit or made a claim in the last 10 years, other than in the present suit relating to any bodily injury?

Yes ________ **No** ________ If **Yes**, please specify the following:

a) Court in which suit/claim filed or made: ________________________________

b) Case/Claim Number: ________________________________

c) Nature of Claim/Injury: ________________________________

2) Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the past 10 years?

Yes ________ **No** ________ If **Yes**, please specify the following:

a) Date (or year) of application: ________________________________

b) Type of benefits sought ______________________

c) Agency/Insurer from which you sought the benefits: ______________

d) The nature of the claimed injury/disability: ______________

e) Whether the claim was accepted or denied: ______________

____

3) Have you ever filed for bankruptcy?

Yes ________ **No** ________ If **Yes**, please specify the following:

a) Court in which petition was filed: ______________

b) Case/claim number: ______________

c) Resolution of case: ______________

VI. <u>FACT WITNESSES</u>

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

Name	Address	Relationship to You

VII. ELECTRONICALLY STORED INFORMATION

For the three years prior to implantation of the Gynecare Mesh Product(s) to present, please identify any websites that you own, maintain, use for social networking, instant messaging, tweeting, blogging, or otherwise posting messages on-line including MySpace and Facebook where you have posted anything with regard to your lawsuit, claims or the Gynecare Mesh Product(s), aside from communications with your attorneys, and provide the name or identity used by you in connection with those websites or postings.

____

____

____

VIII. AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Ethicon, Inc. and/or its attorneys or agents to obtain those records identified in the authorizations, and send those executed authorizations immediately to:

The Marker Group, Inc. 13105 Northwest Freeway Suite 300 Houston, TX 77040 713.460.9070 *main* 713.934.2586 *fax*	**Litigation Management, Inc.** 7976 Mayfield Rd Suite 150 Chesterland, OH 44026 (440) 484-2000

IX. DOCUMENTS

State whether you have any of the following documents in your possession, custody, and/or control. If you do, please provide a true and correct copy of any such documents, with this completed Fact Sheet.

a) If you were appointed by a court to represent the plaintiff in this lawsuit, produce any documents demonstrating your appointment as such.

   i. Not Applicable _____

   ii. The documents are attached _______ [OR] I have no documents ________

b) If you represent the estate of a deceased person in this lawsuit, produce a copy of the decedent's death certificate and autopsy report (if applicable).

   i. Not Applicable _____

   ii. The documents are attached _______ [OR] I have no documents ________

c) Produce any communications in your possession (sent or received) concerning the Gynecare Mesh Product(s), including but not limited to e-mails, text messages, instant messages, letters, blog entries, newsletters, etc. Social media websites, including but not limited to Facebook, MySpace, Twitter, Friendster, are not included within this request and will be addressed later.

   i. Not Applicable _____

   ii. The documents are attached _______ [OR] I have no documents ________

d) Produce all documents or records in your possession relating to the bodily injuries, conditions and/or symptoms identified in your responses to questions II. (3), (3)(a), (10) and (11) of this Fact Sheet.

   i. Not Applicable _____

   ii. The documents are attached _______ [OR] I have no documents ________

e) Produce all documents or records in your possession relating to the surgeries, conditions and/or injuries identified in your responses to questions III. (3), (4) and (6) of this Fact Sheet.

   i. Not Applicable _____

   ii. The documents are attached _______ [OR] I have no documents ________

f) If you are advancing a claim for emotional or psychological injuries, produce all documents or records in your possession which refer or relate to any psychological, psychiatric, counseling, mental health treatment that you have received in the last 10 years.

i. Not Applicable

ii. The documents are attached [OR] I have no documents

g) Produce all documents or records in your possession relating to the prescriptions identified in your response to question III. (13) of this Fact Sheet.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

h) Produce documents, including notes, diary or journal entries, and sufficient photographs, DVDs, videos, or other media to show: (1) the conditions which led to the surgery in which you received a Gynecare Mesh Product, or (2) the injuries or conditions for which you claim relief in this lawsuit. This request is limited to the time period beginning three years prior to your surgery until the present.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

i) Produce any Gynecare Mesh Product packaging, labeling, advertising, patient brochures, or any other Gynecare Mesh Product -related items in your possession.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

j) Produce all documents concerning any communication between you and the Food and Drug Administration (FDA) or between you and any employee or agent of the Defendants, regarding the Gynecare Mesh Product(s) at issue.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

k) Produce all documentation in your possession of correspondence or communication between Ethicon, Inc., Johnson & Johnson (or any of its related companies or divisions) and any of your doctors, healthcare providers, and/or you relating to the Gynecare Mesh Product(s).

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

l) Produce any and all documentation in your possession of any instructions or warnings you received prior to implantation of any Gynecare Mesh Product(s) concerning the risks and/or benefits of your surgery, including but not limited to any risks and/or benefits associated with the Gynecare Mesh Product(s).

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

m) Produce any and all documents reflecting the product code and lot number of the Gynecare Mesh Product(s) you received.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

n) If you claim lost wages or lost earning capacity, copies of your federal and state tax returns for the 5 years prior to your surgery until the present.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

o) Produce any and all statements by any party or any other person with knowledge relevant to this lawsuit, including their agents, servants, employees, officers or directors, regarding the Plaintiff and her condition, excluding work product.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

p) Produce any and all documents regarding monies expended or expenses incurred for hospitals, doctors, nurses, x-rays, medicines and other health care related to the injuries and/or conditions you allege in this action.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

q) Produce any and all documents which itemize any and all other losses or expenses not otherwise set forth, incurred as a result of your injury and/or condition which forms the basis of this action.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

r) Produce any and all documents which identify money which you have received as a result of your injury and/or condition which forms the basis of this lawsuit.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

s) Produce any and all settlement agreements, releases and forms of payment relating to any other legal proceeding related to your claims and alleged injuries.

i. Not Applicable _____

ii. The documents are attached _______ [OR] I have no documents ________

SWORN DECLARATION

Plaintiff, ______________________________, deposes and states as follows:

I certify under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in Section IX of this Fact Sheet to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in Section VIII of this Fact Sheet.

Dated: ____________________ ____
Signature

EXHIBIT A

4933-0439-7863, v. 2

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

Name of Individual:
Social Security Number:
Date of Birth:

Provider Name: ____

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

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

The Social Security Administration

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to **Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 7976 Mayfield Rd., Suite 150, Chesterland, OH 44026;** and their authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, dentists and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results, genetic testing information, and alcohol and drug abuse treatment) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all dental records, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic, hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

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

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

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

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: ______________________ *v. Ethicon, Inc. and Johnson & Johnson, et al.*

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

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice either to Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 7976 Mayfield Rd, Suite 150, Chesterland, OH 44026, and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

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

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler Snow LLP; Riker Danzig LLP; The Marker Group, Inc., and/or Litigation Management, Inc. pursuant to this authorization will be shared with any and all co-defendants in the matter of ______________________ *v. Ethicon, Inc. and Johnson & Johnson, et al* and is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for drug or alcohol abuse, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, Sickle Cell Anemia, Tuberculosis and Genetic testing and counseling.

- I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

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

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 7976 Mayfield Rd., Suite 150, Chesterland, OH 44026; and/or and their authorized representatives, by any entities included in the categories listed above.

Date: ____________________

____
Signature of Individual or Individual's Representative

Individual's Name and Address:

____
Printed Name of Individual's Representative (If applicable)

____

____
Relationship of Representative to Individual (If applicable)

____

____

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

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

AUTHORIZATION AND CONSENT
<u>TO RELEASE PSYCHOTHERAPY NOTES</u>

Name of Individual:
Social Security Number:
Date of Birth:

Provider Name:____

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers
The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to **Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc.**, 7976 Mayfield Rd., Suite 150, Chesterland, OH 44026; and their authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: ____________________________ *v. Ethicon, Inc. and Johnson & Johnson, et al.*
- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either **Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 7976 Mayfield Rd., Suite 150, Chesterland, OH 44026,** and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).
- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler Snow LLP, Riker Danzig LLP, McCarter & English, The Marker Group, Inc. and/or Litigation Management, Inc. pursuant to this authorization will be shared with any and all co-defendants in the matter of ____________________ ________ *v. Ethicon, Inc. and Johnson & Johnson, et al.* and is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).
- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of ____________________**v. Ethicon, Inc. and Johnson & Johnson, et al. or (ii) five (5) years after the date of signature of the undersigned below.**

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 7976 Mayfield Rd., Suite 150, Chesterland, OH 44026 and their authorized representatives, by any entities included in the categories listed above.

Date: ____________________

____
Signature of Individual or Individual's Representative

Individual's Name and Address:

____
Printed Name of Individual's Representative (If applicable)

____

____
Relationship of Representative to Individual (If applicable)

____

____

____

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

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

"Consent to Release"
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Consent to Release" vs. "Proof of Representation"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on

- **When to use a "consent to release" document vs. a "proof of representation" document,**
- Appropriate content for both documents,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

A "consent to release" document is used by an individual or entity who does not represent the Medicare beneficiary but is requesting information regarding the beneficiary's conditional payment information. A "consent to release" does not authorize the individual or entity to act on behalf of the beneficiary or make decisions on behalf of the beneficiary.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Consent to Release" must include the information the model language requests.

Where to Submit a " Consent to Release" document:

Liability Insurance, No-Fault Insurance, Workers' Compensation:
NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

MODEL LANGUAGE

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I ,____________________(print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:
(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company ( ) Workers' Compensation Carrier ( ) Other ________________
(Explain)

Name of entity: Litigation Management, Inc. ("LMI")

Contact for above entity: records@LMI-med.com

Address: 7976 Mayfield Road, Suite 150
Chesterland, OH 44026

Telephone: (888) 803-8706

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION
(The period you check will run from when you sign and date below.):

( ) One Year ( ) Two Years ( ) Other ____________________
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: ____________________ Date signed: ________________

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit http://go.cms.gov/cobro for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): ________________

Date of Injury/Illness: ________________

"Consent to Release"
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Consent to Release" vs. "Proof of Representation"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on

- **When to use a "consent to release" document vs. a "proof of representation" document,**
- Appropriate content for both documents,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

A "consent to release" document is used by an individual or entity who does not represent the Medicare beneficiary but is requesting information regarding the beneficiary's conditional payment information. A "consent to release" does not authorize the individual or entity to act on behalf of the beneficiary or make decisions on behalf of the beneficiary.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Consent to Release" must include the information the model language requests.

Where to Submit a " Consent to Release" document:

Liability Insurance, No-Fault Insurance, Workers' Compensation:
NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

MODEL LANGUAGE

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I ,__________________________(print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company ( ) Workers' Compensation Carrier ( ) Other ________________
(Explain)

Name of entity: RIKER DANZIG LLP

Contact for above entity: Kelly Crawford, Esq.

Address: 7 Giralda Farms, Suite 250
Madison, NJ 07940-1051

Telephone: (973) 538-0800

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION

(The period you check will run from when you sign and date below.):

( ) One Year ( ) Two Years ( ) Other ____________________
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: ______________________ Date signed: ________________

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit http://go.cms.gov/cobro for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): ________________

Date of Injury/Illness: ________________

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶Go to *www.irs.gov/Form8821* for instructions and the latest information.
▶Don't sign this form unless all applicable lines have been completed.
▶Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.

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 6.

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

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached ▶** ☑

Name and address
Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158

CAF No. ______
PTIN ______
Telephone No. ______
Fax No. ______

Check if to be sent copies of notices and communications ☐ Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

Name and address
Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051

CAF No. ______
PTIN ______
Telephone No. ______
Fax No. ______

Check if to be sent copies of notices and communications ☐ Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax information. Each designee 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.

☐ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(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 the 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 line 5 . . . . ▶ ☐

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 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 5 instructions.

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

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

▶DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature ______ Date ______

Print Name ______ Title (if applicable) ______

ADDITIONAL DESIGNEES

The Marker Group, Inc.
13105 Northwest Freeway, Suite 300
Houston, TX 77040

Litigation Management, Inc.
7976 Mayfield Rd., Suite 150,
Chesterland, OH 44026

Form **4506**

(September 2024)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number or individual taxpayer identification number if joint tax return

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

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

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

Litigation Management Inc ("LMI") Attn. records@LMI-med.com, 7976 Mayfield RD, Ste 150, Chesterland, OH 44026

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ ____________

Note: If the copies must be certified for court or administrative proceedings, check here . . . . ☐

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

___/___/___ ___/___/___ ___/___/___ ___/___/___

___/___/___ ___/___/___ ___/___/___ ___/___/___

8 **Fee.** There is a $30 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order**

a	Cost for each return	$ 30.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been complete

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506. See instructions**

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) — Date

▶ Print/Type name — Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** — Date

▶ Print/Type name

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

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

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

How long will it take? It may take up to 75 calendar days for us to process your request.

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

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

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Arizona, Arkansas, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, California, Colorado, Hawaii, Idaho, Kansas, Michigan, Montana, Nebraska, Nevada, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

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

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

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

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

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

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

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

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

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

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

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

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

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

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

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

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

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

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

Form **4506**

(September 2024)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number or individual taxpayer identification number if joint tax return

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

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

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

RIKER DANZIG LLP, Attn: Kelly Crawford, Esq., 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ ______________

Note: If the copies must be certified for court or administrative proceedings, check here . . . . ☐

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

___/___/_____   ___/___/_____   ___/___/_____   ___/___/_____

___/___/_____   ___/___/_____   ___/___/_____   ___/___/_____

8 **Fee.** There is a $30 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order**

a	Cost for each return	$ 30.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been complete

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506. See instructions**

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) | Date

▶ Print/Type name | **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** | Date

▶ Print/Type name

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

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

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

How long will it take? It may take up to 75 calendar days for us to process your request.

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

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

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Arizona, Arkansas, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, California, Colorado, Hawaii, Idaho, Kansas, Michigan, Montana, Nebraska, Nevada, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

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

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

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

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

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

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

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

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

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

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

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

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

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

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

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

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

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

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

Form **4506**

(September 2024)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

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

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

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

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

The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040 713-934-2740 and Litigation Management Inc., 7976 Mayfield Rd, Suite 150, Chesterland, OH 44026 800-778-5424

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ ____________

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

__/__/____ __/__/____ __/__/____ __/__/____

__/__/____ __/__/____ __/__/____ __/__/____

8 **Fee.** There is a $30 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order**

a	Cost for each return	$ 30.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . ☐

Caution: Do not sign this form unless all applicable lines have been complete

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506. See instructions**

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) Date

▶ Print/Type name Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** Date

▶ Print/Type name

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

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

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

How long will it take? It may take up to 75 calendar days for us to process your request.

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

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

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Arizona, Arkansas, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, California, Colorado, Hawaii, Idaho, Kansas, Michigan, Montana, Nebraska, Nevada, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

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

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

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

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

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

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

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

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

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

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

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

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

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

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

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

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

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

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

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION FORM

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 CCO, 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.** 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".

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

- **Option 1** To **include** all information, check the box: "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, check the box "Exclude information about alcohol and drug abuse, mental health treatment, and HIV". 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

Enclosure

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

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.
   - 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. Box 2C must be completed by New York Residents.

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. This section tells Medicare the reason for disclosure.

5. 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.

6. 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).

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

8. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number seven 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.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice** or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

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, Middle, Last, Suffix) of the person with Medicare

Medicare Identification Number (if issued), 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 one 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 only 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)

____
____
____

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

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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 reason for the disclosure (you may write "at my request"):**

Civil Litigation

5. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

Name The Marker Group, Inc.

Address 13105 NW Freeway, Suite 300, Houston, TX 77040

Name Litigation Management, Inc.

Address 7976 Mayfield Rd., Suite 150, Chesterfield,OH 44026

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. To revoke authorization, send a written request to the address noted below. 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.

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

6.

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 Personal Representative: ______________________________

Personal Representative's Relationship to the Beneficiary: ______________________________

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

7. Send the completed, signed authorization to:

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

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 authorization, send a written request to the address noted 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.

ADDITIONAL ORGANIZATIONS/RECIPIENTS

Organization / Recipient 2 Name and Mailing Address:

Riker Danzig LLP, 7 Giralda Farms, Suite 250, Madison, NJ 07940-1051

Organization / Recipient 3 Name and Mailing Address:

The Marker Group, Inc.,13105 Northwest Freeway, Suite 300, Houston, Tx 77040

Organization / Recipient 4 Name and Mailing Address:

Litigation Management, Inc., 7976 Mayfield Rd., Suite 150, Chesterland, OH 44026

4871-5646-7828, v. 1

Consent for Release of Information

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). You may complete this form to release only the minor's non-medical records, if you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child. We require proof of relationship, if you are not the subject of the record. We may charge a fee for providing the information, if you are requesting the information for a purpose unrelated to the administration of a program under the Social Security Act. If you are requesting information, such as a Social Security Statement or benefit verification letter, you can also access this information by creating an account at https://www.ssa.gov/myaccount/.

NOTE: Do NOT use this form to request:

- **The release of a minor child's medical records. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or**
- **Detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local 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 "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in the name, date of birth, and social security number of the subject of the record.
- Fill in the name and address of the person or organization of where you want us to send the requested information.
- Specify the reason you want us to release the information (e.g., litigation, investigation, determining eligibility for benefits). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child or legally incompetent adult, you must state how the release of information is in the best interest of the minor child or legally incompetent adult.
- Check the box next to the type(s) of information you want us to release including specific date ranges, where applicable.

NOTE: Unless otherwise specified, the consent form is valid for one-time use only. Also, it is valid for one year from the date of signature, unless you are requesting medical records. A consent form that includes a request for medical records is valid for 90 days from the date of signature.

Send or bring the completed form to the subject of the record's local servicing office. To locate the appropriate servicing office, visit https://secure.ssa.gov/ICON/main.jsp, and input the subject of the record's ZIP code.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (**Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:** **** PHONE NUMBER OF PERSON OR ORGANIZATION:**
The Marker Group, Inc.	*13105 Northwest Freeway, Suite 300, Houston, TX 77040
	**713-934-2740
Litigation Management, Inc.	7976 Mayfield Rd Ste 150, Chesterland OH 44025 8007785424

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check <u>both</u> boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date ____________ to date ____________
5. ☐ Supplemental Security Income payment amounts from date ____________ to date ____________
6. ☐ Medicare entitlement from date ____________ to date ____________
7. ☐ Medical records from date ____________ to date ____________
8. ☐ Complete medical records
9. ☐ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

I am the individual, to whom the requested information or 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 (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** ____________________ ***Date:** ____________

****Address:** ____________________ ****Daytime Phone:** ____________

****Relationship (if not the subject of the record):** ____________ ****Daytime Phone:** ____________

Witnesses must sign this form ONLY if the above signature is by mark (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)

Privacy Act Statement
Collection and Use of Personal Information

The Privacy Act (5 U.S.C. 552a) and Section 205(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from honoring the request to release information or records about you. We will use the information you provide to respond to the request for Social Security Administration (SSA) records. We may share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0340, entitled FOIA and Privacy Act Record Request and Appeal System, as published in the FR on July 13, 2016, at 81 FR 45352. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 5 minutes to read the instructions, gather the facts, and answer the questions. 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.***

Consent for Release of Information

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). You may complete this form to release only the minor's non-medical records, if you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child. We require proof of relationship, if you are not the subject of the record. We may charge a fee for providing the information, if you are requesting the information for a purpose unrelated to the administration of a program under the Social Security Act. If you are requesting information, such as a Social Security Statement or benefit verification letter, you can also access this information by creating an account at https://www.ssa.gov/myaccount/.

NOTE: Do NOT use this form to request:

- **The release of a minor child's medical records. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or**
- **Detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local 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 "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in the name, date of birth, and social security number of the subject of the record.
- Fill in the name and address of the person or organization of where you want us to send the requested information.
- Specify the reason you want us to release the information (e.g., litigation, investigation, determining eligibility for benefits). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child or legally incompetent adult, you must state how the release of information is in the best interest of the minor child or legally incompetent adult.
- Check the box next to the type(s) of information you want us to release including specific date ranges, where applicable.

NOTE: Unless otherwise specified, the consent form is valid for one-time use only. Also, it is valid for one year from the date of signature, unless you are requesting medical records. A consent form that includes a request for medical records is valid for 90 days from the date of signature.

Send or bring the completed form to the subject of the record's local servicing office. To locate the appropriate servicing office, visit https://secure.ssa.gov/ICON/main.jsp, and input the subject of the record's ZIP code.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (**Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:** **** PHONE NUMBER OF PERSON OR ORGANIZATION:**
Litigation Management, Inc. ("LMI")	RIKER DANZIG LLP
7976 Mayfield Road, Suite 150	7 Giralda Farms, Suite 250
Chesterland, OH 44026	Madison, NJ 07940-1051

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

____

____

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
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6. ☐ Medicare entitlement from date __________ to date __________
7. ☐ Medical records from date __________ to date __________
8. ☐ Complete medical records
9. ☐ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

____

____

I am the individual, to whom the requested information or 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 (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** ____________________ ***Date:** __________

****Address:** ____________________ ****Daytime Phone:** __________

****Relationship (if not the subject of the record):** __________ ****Daytime Phone:** __________

Witnesses must sign this form ONLY if the above signature is by mark (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)

Privacy Act Statement
Collection and Use of Personal Information

The Privacy Act (5 U.S.C. 552a) and Section 205(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from honoring the request to release information or records about you. We will use the information you provide to respond to the request for Social Security Administration (SSA) records. We may share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0340, entitled FOIA and Privacy Act Record Request and Appeal System, as published in the FR on July 13, 2016, at 81 FR 45352. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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