SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER CASE NO. ATL-L-173-20

CASE NO. 633
Civil Action

IN RE PROLENE HERNIA SYSTEM MESH LITIGATION

CASE MANAGEMENT ORDER NO. 22 [REQUIREMENTS FOR RECORD PRESERVATION AND *PRIMA FACIE* EVIDENCE OF IMPLANT, INJURY AND CAUSATION]

This matter having been opened to The Court by the Defendants; and good cause appearing,

IT IS on this 15th day of November, 2022,

This Order applies to all Plaintiffs with personal injury claims filed in, removed to, or transferred to this MCL on or after the date of entry of this Case Management Order. This Case Management Order requires all such Plaintiffs to comply with certain preservation obligations and to produce certain specified information regarding their claim. Plaintiffs who represent themselves *pro se* in this proceeding shall be bound by the requirements of this Case Management Order and shall fully comply with all obligations required of counsel by this Order, unless otherwise stated.

I. PRESERVATION NOTICE REQUIREMENT

A. For all cases filed on or after the date of entry of this Case Management Order, after the case is docketed in this Court (either through direct filing in the New Jersey In re Prolene Hernia System Mesh Litigation MCL ("PHS MCL") or transferred to the PHS MCL), counsel for Defendants shall serve upon counsel for Plaintiff (or if a Plaintiff is proceeding *pro se*, the Plaintiff) a copy of this Case Management Order. Within 14 days of receipt of notice of this Case Management Order from counsel for Defendants, counsel for Plaintiff (or if a Plaintiff is proceeding *pro se*, the Plaintiff) shall send a Notice to the following individuals or entities,

advising that the individual or entity may have records relevant to the Plaintiff's Claim in this PHS MCL proceeding and that any records relating to the Plaintiff must be preserved pending collection by Plaintiff:

1. All pharmacies that dispensed any medication to the Plaintiff related to any and all claims and/or alleged injuries for the period from five (5) years prior to the date of the alleged injury claimed to the present; and
2. All physicians, medical facilities, other healthcare providers and/or other persons who implanted or explanted PHS in or from Plaintiff or otherwise treated the Plaintiff related to any and all claims in the case, including abdominal surgeries and/or hernia-related pain or injuries.

B. Counsel for Plaintiff (or if a Plaintiff is proceeding *pro se*, the Plaintiff) shall serve a signed certification verifying that Notices were sent and attach copies of the Notices with the certification. This will be done within 45 days of receipt of notice of this Case Management Order from counsel for the Defendants.

1. Plaintiffs shall serve the certification required by this Paragraph, and all other materials required to be served pursuant to this Order by one of the following methods:
    a. By email to **NJPHSMCL**@butlersnow.com; or
    b. By United States Mail or other carrier, post-marked on or before the deadlines set forth in this Paragraph (with return receipt) to the following: Amelias McKinney, Butler Snow, LLP, P.O. Box 6010, Ridgeland, MS, 39158-6010.

II. DISCOVERY REQUIREMENTS

A. All Plaintiffs subject to this Case Management Order shall produce the following documents and/or information:

1. A Plaintiff Fact Sheet ("PFS") and signed, but undated authorizations attached hereto as Exhibit A;

2. All medical records relating to the Plaintiff from all healthcare providers who received notice pursuant to paragraphs I.A.1 and I.A.2. above, and which must further include product identification, implant and explant records, and any records relating to PHS, the claims and/or alleged injuries; and

3. An affidavit signed by the Plaintiff or his/her counsel (i) attesting that to the best of his/her knowledge, all medical records described in subparagraph II.A.2. have been collected; and (ii) attesting that all records collected have been produced pursuant to this Case Management Order.

B. If any of the documents or records described in Section II.A.2 above do not exist, the signed affidavit by Plaintiff or Plaintiff's counsel shall state that fact and the reasons, if known, why such materials do not exist, and shall make every effort to provide a "No Records Statement" from the healthcare provider, where available.

C. Plaintiffs shall produce the items required in Sections II.A. and II.B. above within 90 days of receipt of notice of this Case Management Order from counsel for Defendants.

D. All Plaintiffs shall also produce expert reports in compliance with New Jersey Court Rules as follows:

1. A New Jersey Court Rule 4:17-4(e) case-specific expert report concerning the specific causation of the Plaintiff's alleged injury. The case-specific expert report should include, at a minimum, a precise identification of the Plaintiff's implant

with PHS, the reasons for the implant, and the nature of the Plaintiff's alleged injury, along with the details of any medical exams, testing, diagnosis or treatment relied upon to support any claimed injury; a statement that the expert believes to the appropriate degree of medical certainty that PHS caused Plaintiff's alleged injury, along witha description of all facts, medical and scientific literature or other authorities relied upon by the expert to support such opinion; and the medical records relied upon in forming the expert's opinion. Nothing in this Case Management Order shall preclude, upon leave of Court or in accordance with other applicable law or Order, amendment of case-specific expert reports prior to trial.

2. Plaintiffs shall produce expert reports required in Section II.D. above within 120 days of receipt of notice of this Case Management Order from counsel for the Defendants.

E. Any Plaintiff may seek relief from the obligations of this Order by motion to the Court. Absent relief being granted by the Court, any Plaintiff who fails to comply with the requirements of Section II shall be given notice of such failure by email from Defendants' counsel and shall be provided 45 additional days to cure such deficiency ("Cure Period") to be calculated from the receipt of such notice of deficiency from counsel for the Defendants. If Plaintiff fails to cure the deficiency within the Cure Period, Defendants may file any appropriate dispositive motions. Plaintiff shall thereupon have 14 days to respond to the Motion and show why the requested relief should not be granted.

F. To the extent that this Case Management Order conflicts with any deadlines or provisions of the Fifth Amended Case Management Order No. 5 [Discovery, Scheduling and Case

Management – Initial Discovery Pool] entered and filed on February 10, 2022, this Case Management Order shall govern.

G. Within 60 days of the service of the expert report required in Sections II.D.1 and II.D.2 of this Case Management Order, Plaintiff's counsel shall make Plaintiff available for deposition. The parties will meet and confer about the location of the deposition and/or whether the deposition will proceed remotely or in person.

III. STAY OF THIS LITIGATION

A. Other than cases subject to this Case Management Order No. 22, this Litigation is stayed and all deadlines are suspended pending further order of The Court.

HON. JOHN C. PORTO, P.J.Cv.

EXHIBIT A

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER CASE NO. ATL-L-173-20

IN RE PROLENE HERNIA SYSTEM (PHS) LITIGATION	CASE NO. 633 Civil Action **PLAINTIFF FACT SHEET**

[INITIAL, FIRST AMENDED, SECOND AMENDED] PLAINTIFF FACT SHEET OF [Add Plaintiff Name]

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If you cannot recall all of the details requested, please provide as much information as you can and then state that your answer is incomplete and explain why as appropriate. If any information you need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with your attorney so that you can fully and accurately respond to the questions set out below. If you are completing the Fact Sheet for someone who cannot complete the Fact sheet themselves, please answer as completely as you can.

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The Plaintiff Fact Sheet shall be completed without objections as to the question posed in the Plaintiff Fact Sheet. This section does not prohibit a Plaintiff from withholding or redacting information from medical or other records provided with the Plaintiff Fact Sheet based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, Plaintiff shall provide Defendants with a privilege log that complies with the Rules Governing the Courts of The State of New Jersey. Further, as indicated in this Order Plaintiffs may object on relevance grounds to the production of litigation funding documents, for further consideration by the Court.

The Plaintiff Fact Sheet will not be interpreted to limit the scope of inquiry at depositions nor will they affect whether evidence is admissible at trial. The admissibility of information in the Plaintiff Fact Sheet is governed by the Rules Governing the Courts of The State of New Jersey, and objections to admissibility are not waived by virtue of the completion and service of a Plaintiff Fact Sheet. Consistent with their obligations under the Rules Governing the Courts of The State of New Jersey, the plaintiff is under a continuing obligation to timely supplement or amend Plaintiff Fact Sheets and responsive documentation.

In any case where a deposition of the Plaintiff is scheduled, Plaintiff must submit any supplement and/or amendments, to the extent applicable and to the extent the material is within the Plaintiff's or his/her attorney's possession, at least 14 days before the date of Plaintiff's deposition, or as soon as practicable thereafter.

Any Plaintiff who undergoes revision surgery or other surgical procedure related to the claims at issue in the case after completing and serving a Plaintiff Fact Sheet must complete and serve an updated Plaintiff Fact Sheet (including providing any additional responsive documentation) within 90 days after the date of

the surgery or 90 days after Plaintiffs' counsel becomes aware of such surgery or procedure, whichever is later.

A completed Fact Sheet shall be considered interrogatory answers pursuant to Rule 4:17 of the Rules Governing the Courts of The State of New Jersey and as responses to requests for production pursuant to Rule 4:18 of the Rules Governing the Courts of The State of New Jersey. The questions and requests for production contained in the Fact Sheet shall be answered without objection. Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, the term "You" means the person who was treated with Prolene Hernia System (PHS).

In completing this form please use the following definition: "healthcare provider" means any 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, or other persons or entities involved in the diagnosis, care and/or treatment of you.

If you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information. Any amended or corrected Plaintiff fact sheets must also include a new signed/dated verification.

I. CASE INFORMATION

1. Caption: _____

   Docket No.: _____

2. Primary attorney contact (name, address, phone, and email):

   _____

3. Full name of the person completing this form, if different from the person listed in the caption above, and the relationship of the person completing this form to the person listed in the caption above (Representative, Guardian, Other):

   _____

II. PLAINTIFF INFORMATION

1. Name of individual implanted with Prolene Hernia System (PHS) _____

   a. ❑Male ❑Female

   b. Date of birth: _____

   c. Last four digits of Social Security No.: _____

   d. Other names by which you have been known (from prior marriages or otherwise):

   _____

2. Spouse name: _____ Loss of Consortium Claim? ❑Yes ❑No

3. Name of Estate Representative if individual implanted with PHS is deceased or is not the filing party:

4. Have you ever filed for bankruptcy: ❑Yes ❑No

   If so, identify the court/state of filing, caption of the case, docket number, and the date of filing and current status: _____

5. Address: _____

   a. How long have you lived at your current address: _____

   b. Provide the following for each of your prior residence from 2000 to the present:

Prior Address	Dates You Lived at Each Address

c. Where did you reside (city and state) at the time of your PHS implantation surgery?

_____

d. Where did you reside (city and state) at the time of your PHS explant or revision surgery (if applicable)? _____

6. Identify the name, relationship, and current age of any person who currently resides with you:

a. Identify the name, relationship, and age (at that time) of any person who was residing with you at the time of your PHS implantation surgery:

_____

_____

_____

b. Identify the name, relationship, and age (at that time) of any person who was residing with you at the time of the PHS explant or revision surgery (if applicable):

_____

_____

_____

7. Have you ever been married? ❑Yes ❑No

If Yes, provide the following:

Spouse First and Last Name (Current)	Dates of Marriage	If Applicable: Reason for End of Marriage (e.g., death, divorce).	Spouse's Current Address and Telephone Number

8. Provide the full name and current age of each of your children, if any. Please provide the address of any child over the age of 18.

Name	Address	Age

9. Have you ever served in any branch of the military? ❑Yes ❑No

a. If Yes, please provide the following information:

Branch and dates of service, rank upon discharge, and the type of discharge you received:

_____

b. Were you discharged from the military at any time due to your medical, physical, or psychiatric condition? ❑Yes ❑No

If Yes, state what that condition was:

_____

10. In the 10 year period before implantation of the PHS, were you examined or treated for any medical condition at a Veterans' Affairs facility? ❑Yes ❑No

If Yes, identify the applicable Veterans' Affairs facility, the condition(s) treated, and approximate date(s) of treatment that condition was: _____

_____

11. Have you ever been convicted of, or pleaded guilty to, a felony and/or crime of fraud or dishonesty? ❑Yes ❑No

If Yes, please set forth the felony and/or crime, the date of the conviction or plea, the court, and docket number: _____

12. Have you or anyone acting on your behalf had any communication, oral or written, with Johnson & Johnson, Ethicon, Inc., or their representatives, other than through your attorneys?

❑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 Johnson & Johnson, Ethicon, Inc., or their representatives:

13. Did you respond to a television or media advertisement relating to hernia mesh lawsuits. ❑Yes ❑No

If Yes, state the date(s) (or approximate date if exact date not known) when you responded, the name of the entity you contacted, and the contact information for the entity you contacted (if you know):

14. Are you now or have you ever been a member of Facebook, LinkedIn, Instagram, Twitter, or any other social media websites? ❑Yes ❑No

If Yes, provide the following information:

Name of Social Media Site(s)	Plaintiffs Username(s)/Handle(s)	Approximate Date(s) of Use

15. Identify any claim you have made, whether in the nature of a lawsuit, demand, or other request for damages against any implanting or treating physician or hernia mesh manufacturer related to the implant at issue in this case, any other hernia mesh implants you have received, and/or the injuries you claim are caused by the PHS implant.

16. Has Plaintiff entered into any agreement with any third-party regarding funding of Plaintiff's civil action?

❑Yes ❑No

If YES please attach the Agreement. If the Agreement is not provided please provide a privilege log in accordance with Rule 4:10-2(e) setting forth the basis for not providing the Agreement (whether an objection on relevance grounds or privilege).

III. CONSORTIUM PLAINTIFF INFORMATION (IF APPLICABLE)

1. Name: _____,

   a. Other names (maiden name, prior marriages, etc.):_____

   b. Date of birth: _____

   c. Last four digits Social Security No.: _____

   d. Address: _____

2. Are you now or have you ever been a member of Facebook, LinkedIn, Instagram, Twitter, or any other social media websites? ❑Yes ❑No

   If Yes, provide the following information:

Name of Social Media Site(s)	Plaintiffs Username(s)/handle(s)	Approximate Date(s) of Use

3. Have you ever been convicted of, or pleaded guilty to, a felony and/or crime of fraud or dishonesty? ❑Yes ❑No

   If Yes, please set forth the felony and/or crime, the date of the conviction or plea, the court, and docket number: _____

4. Please list the name and address of any healthcare providers you have seen for treatment for any injuries or symptoms alleged to be related to the loss of consortium claim, if any.

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

IV. PHS DEVICE INFORMATION

1. Date of implant: _____

a. Reason the PHS was implanted: _____

b. PHS Size: _____

c. Lot Number: _____

d. Product Code: _____

e. Implanting Surgeon: _____

f. Medical Facility: _____

g. Additional products implanted during same procedure (if any): _____

2. For the PHS identified above, indicate if, prior to implantation, you received any written and/or verbal information or instructions, including any risks or complications that might be associated with the use of the product(s)?

❑Yes ❑No ❑Do not recall

If Yes:

a. Provide the date you received the written and/or verbal information or instructions:

_____

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

_____

c. Describe in detail the information or instructions received: _____

3. For the PHS identified above, did you receive post-operative surgical care instructions and/or restrictions that were provided either written and/or verbally?

❑Yes ❑No ❑Do not recall

If Yes:

a. Provide the date(s) you received the written and/or verbal instructions and/or restrictions:

_____

b. Identify by name, if known, and address the person(s) who provided the instructions and/or restrictions: _____

c. Describe the instructions and/or restrictions received: _____

d. If you have copies of the written instructions or restrictions you received, please separately upload a true and correct copy of any such documents with this completed Fact Sheet.

4. For the PHS that remains implanted in you:

   a. Has any doctor or healthcare professional recommended removal or revision of the PHS(s)? ❑Yes ❑No

      If Yes:

      a. Identify by name and address the doctor who recommended removal:

      _____

      b. State your understanding of why the doctor recommended removal:

      _____

   b. Has any doctor or health care provider advised you not to have the PHS removed or revised? ❑Yes ❑No

      If Yes:

      a. Identify by name and address the doctor or healthcare professional who recommended not having the product removed/revised: _____

      b. State your understanding of why the doctor recommended that you not have the product removed/revised: _____

5. Have you filed a lawsuit or asserted any claim related to any other product implanted during the same procedure as the PHS implant(s)? ❑Yes ❑No ❑N/A

   If Yes, identify the claim/lawsuit asserted, the court, docket number, the date the claim/lawsuit was made, the injuries alleged, and the name/address of any counsel representing you in such claim/lawsuit:

V. REMOVAL/REVISION SURGERY INFORMATION

1. Date of revision/explant surgery(ies): _____

   a. Description of revision/explant surgery(ies): _____

   b. Revising/Explanting surgeon(s): _____

   c. Medical Facility(ies):_____

   d. Reason(s) you believe PHS was removed/revised:

   _____

   e. Does any medical treater, physician or anyone else on your behalf have possession of any portion of the PHS that was previously implanted in you and removed?

   ❑Yes ❑No ❑Do Not Know

If Yes, please state name and address of the person or entity having possession of same:

_____

If No, do you know whether the removed portion of your PHS was destroyed? ❑Yes ❑No ❑Do Not Know

If Yes, describe how you know and identify who destroyed it:

_____

VI. OUTCOME ATTRIBUTED TO DEVICE

1. Do you claim that you suffered injuries as a result of the implantation of PHS?

❑Yes ❑No ❑Do Not Know

If Yes:

a. Please describe in detail the physical injury(ies) you claim were caused as a result of your use of the PHS:

_____

_____

_____

b. When did you first attribute these bodily injuries to the PHS?

_____

c. Please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries listed above.

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

2. Are you currently experiencing any physical or bodily injuries as a result of your PHS? ❑Yes ❑No

If Yes, please describe your current symptoms in detail if different than that which is set forth in Question A.1. above.

_____

a. Are you currently seeing a doctor or healthcare provider for any of the injuries listed above? ❑Yes ❑No

b. Other than those doctors listed in the chart above, please list all doctors you are currently seeing for treatment of the injuries listed above:

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

3. Do you claim that you have suffered a psychiatric or psychological injury requiring medical treatment as a result of the implantation of the PHS? ❑Yes ❑No

If Yes:

a. Describe in detail the psychiatric or psychological injuries that you claim you are currently experiencing: _____

b. Are you currently seeing a doctor or healthcare provider for any of the psychiatric or psychological injuries listed above? ❑Yes ❑No

c. Other than those doctors listed in the chart above, please list all doctors you are currently seeing for treatment of the psychiatric or psychological injuries listed above:

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

VII. ADDITIONAL HERNIA MESH PRODUCTS

Other than the PHS product(s) that is the subject of your lawsuit, have you been implanted with any other hernia mesh products? ❑Yes ❑No

If Yes, please provide the following information:

a. Product Name(s): _____

b. Date of implantation procedure(s) and name and address of implanting doctor(s): _____

c. Condition(s) sought to be treated through placement of the device(s): _____

d. To the best of your knowledge, did you experience any complications during the recovery period following the procedure(s)? ❑Yes ❑No

If Yes, describe in detail any complications or difficulties you experienced during your recovery following the procedure(s): _____

e. Whether the product(s) remain implanted inside of you today? ❑Yes ❑No

If no, identify when revised/removed and your understanding as to the reason for the revision/removal: _____

f. Have you filed a lawsuit or asserted any claim related to any other hernia mesh products? ❑Yes ❑No ❑N/A

If Yes, identify the claim/lawsuit asserted, the court, docket number, the date the claim/lawsuit was made, the injuries alleged, and the name/address of any counsel representing you in such claim/lawsuit:

_____

g. Has any doctor or health care provider advised you not to have the additional hernia mesh product removed or revised? ❑Yes ❑No

If Yes:

a. Identify by name and address the doctor or healthcare professional who recommended not having the product removed/revised: _____

h. State your understanding of why the doctor recommended that you not have the product removed/revised: _____

_____

_____

VIII. EDUCATION INFORMATION

1. Identify your educational background, starting with high school and including any technical or post-secondary education, in reverse chronological order (most recent education listed first):

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

IX. EMPLOYMENT INFORMATION

1. Please provide the following information for your employment history from 2010 to the present in reverse chronological order (most recent employment listed first):

Employer Name	Address	Job Title/ Description of Duties	Dates of Employment	Annual Salary before taxes, or Rate of Pay

2. Do/Did any of the employment positions listed above require you to lift/carry/hold heavy objects? ❑Yes ❑No

   If Yes, describe such lifting requirements, including in your response, without limitation, the frequency with which you are/were required to lift/carry/hold such objects.

3. In the 10 years prior to your PHS implant, have you ever missed work for more than 10 consecutive days for reasons related to your health? ❑Yes ❑No

   If Yes, describe the date(s) of any such absence and the health condition that prevented you from working. _____

X. ALLEGED DAMAGES

1. Are you claiming damages for lost wages? ❑Yes ❑No

   If Yes:

   a. Identify the time period you contend that you lost wages as a result of the injuries you contend resulted from the PHS: _____

   b. What is the total amount of wages you are claiming you have lost as a result of your claims in this case as of the date this form is executed? _____

   c. State the annual gross income you derived from your employment for each year, beginning five years prior to the implantation of the PHS until the present: _____

2. Are you or your spouse claiming lost out-of-pocket expenses? ❑Yes ❑No

   If Yes:

   a. As of the date this form is executed, what is the total amount of out-of-pocket expenses you are claiming you have lost as a result of your claims in this case?

   _____

   b. Identify and itemize each individual out-of-pocket expense you are seeking to recover in this case which you contend resulted from the PHS:

   _____

XI. MEDICAL BACKGROUND

1. Current Height: _____ Current Weight: _____

2. Weight at the time you received the PHS(s) _____

3. Smoking Status (including cigarettes, cigars and pipe tobacco) (check applicable):

   - Current Smoker ❑
   - Past Smoker ❑
   - Non Smoker ❑

   If you checked current or past smoker, indicate the tobacco products you have smoked (check applicable):

   - Cigarettes ❑
   - Cigars ❑
   - Pipe Tobacco ❑
   - Other ❑

   If Other, please specify: _____

If you checked current smoker, how much do you smoke? _____

If you checked current smoker, how many years have you smoked? If you checked past smoker, approximately when did you quit? _____

If you checked past smoker, how much did you smoke before you quit? _____

If you checked past smoker, how many years did you smoke before you quit? _____

4. Prior to the first PHS implant, to the best of your knowledge, have you ever had:

Diabetes: ❑Yes ❑No

If Yes, what type and when diagnosed?

_____

Adhesions or Adhesive Disease: ❑Yes ❑No

If Yes, describe (including date diagnosed and treatment received):

_____

Connective Tissue Disorders (such as Ehlers-Danlos and Marfan's Syndrome)

❑Yes ❑No

If Yes, describe (including date diagnosed and treatment received):

_____

Irritable Bowel Syndrome: ❑Yes ❑No

If Yes, when diagnosed? Lupus: ❑Yes ❑No

_____

If Yes, when diagnosed? _____

Auto Immune Disorder: ❑Yes ❑No

If Yes, identify (including date diagnosed and treatment received) _____

_____

Anemia or other blood disorder: ❑Yes ❑No

If Yes, identify (including date diagnosed) _____

_____

Respiratory disease, including Asthma, Emphysema, and/or COPD: ❑Yes ❑No

If Yes, identify (including date diagnosed): _____

_____

Any disease of the gut, abdomen, intestines, or bowels: ❑Yes ❑No

If Yes, identify (including date diagnosed and treatment received): _____

_____

Any abdominal surgery(ies): ❑Yes ❑No

If Yes, identify (including date of procedure): _____

_____

Prescribed medication to treat constipation: ❑Yes ❑No

_____

If Yes, identify the medication, who prescribed, and when prescribed:

_____

Prescribed medication to treat bronchitis: ❑Yes ❑No

If Yes, identify the medication, who prescribed, and when prescribed:

_____

Sought treatment for enlarged prostate or straining to urinate: ❑Yes ❑No

_____

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

Sleep Apnea: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

Conditions requiring use of Steroids, Immune Suppression or Chemotherapy: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

Ascites: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

Cystic fibrosis: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

Chronic lung infections: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

Collagen Disorders: ❑Yes ❑No

If Yes, identify the disorder, treatment received, provider(s) seen, and dates of treatment:

_____

Fibromyalgia or other chronic pain condition: ❑Yes ❑No

If Yes, identify, describe the treatment received, provider(s) seen, and dates of treatment:

_____

Fistula(s): ❑Yes ❑No

If Yes, identify the location, treatment received, provider(s) seen, and dates of treatment:

_____

Bowel Obstruction: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

Bowel Perforation: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

5. Other than the hernia(s) the PHS or other hernia mesh product(s) identified in Section VII above was/(were) intended to treat, have you ever had any other hernia(s)? ❑Yes ❑No

   If Yes:

   a. Describe when each hernia was diagnosed:

   _____

   b. Describe the location of each hernia:

   _____

   c. Describe the type of hernia (if known):

   _____

   d. Describe whether the hernia was repaired surgically (including the date of any such repair, the surgeon who performed the repair, and the facility where the repair was performed):

   _____

   e. To the best of your knowledge, did you experience any complications during the recovery period following the procedure(s)? ❑Yes ❑No

   If yes, describe in detail any complications or difficulties you experienced during your recovery following the procedure(s): _____

6. In chronological order, list any and all pelvic or abdominal surgeries and/or hospitalizations relating to the pelvic or abdominal region you have had in the 10 year period BEFORE implantation of the PHS(s); identifying by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved; and providing the approximate date(s) for each.

Doctor or Healthcare Provider Involved (including address)	Description of Surgery and/or Hospitalization	Approximate. Date

7. In chronological order, list any and all surgeries, procedures, or hospitalizations you had AFTER the implantation of the PHS(s); 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.

Doctor or Healthcare Provider Involved (including address)	Description of Surgery and/or Hospitalization	Approximate. Date

8. Describe how, if at all, you contend your physical activities associated with daily living, physical fitness (including any weightlifting), household tasks, and employment-related activities have changed as a result of the implantation of the PHS.

9. For female plaintiffs, have you previously given birth? ❑Yes ❑No

   If Yes:

   a. How many births and dates of each birth? _____

   b. If any of the births were by cesarean section, please state the number of cesarean section births: __

10. List each prescription medication you have taken **for more than 45 consecutive days, within five years prior to the PHS implant to 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.

Prescription Medication	Name of Pharmacy and Address

11. Identify the name and address of any pharmacy where you received/filled any prescription medication within the last 10 years.

Name of Pharmacy	Address

XII. LIST OF MEDICAL PROVIDERS

1. To the extent not already provided above, list all treating physicians or other medical providers you have seen for the period of 10 years prior to the first PHS implant to the present, including, but not limited to, all primary care physicians, internists, general surgeons, psychiatrists, urologists,

endocrinologists, rheumatologists, or any other specialists. You do not have to list mental healthcare providers if you are not claiming psychological injuries as part of this lawsuit.

Provider Name, Address and Specialty	Condition Treated	Approximate Date of Treatment

XIII. INSURANCE INFORMATION

1. Provide the following information 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. Have you ever been denied life insurance for reasons relating to your health?

❑Yes ❑No ❑Do Not Know

If Yes, please state when the denial occurred, the name of the life insurance company, and the company's reason for denial: _____

3. To the best of your knowledge, have you been approved to receive or are you receiving Medicare benefits due to age, disability, condition or any other reason or basis?

❑Yes ❑No ❑Do Not Know

If Yes, please specify the date on which you first became eligible: _____

[*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*]

XIV. PRIOR CLAIM INFORMATION

1. Have you filed a lawsuit or made a claim within the last 10 years prior to implant to present, 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 and specific injuries alleged: _____

2. Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the last 10 years prior to implant to present? ❑Yes ❑No

   If Yes, please specify the following: _____

   a. Date (or year) of application: _____

   b. Type of benefits sought: (check applicable): _____

   - Workers' Compensation ❑
   - Social Security Disability ❑
   - Other ❑

   If Other, please specify the type of benefits sought: _____

   c. Agency/Insurer from which you sought the benefits: _____

   d. The nature of the claim and specific injuries/disability alleged: _____

   e. Whether the claim was accepted or denied: _____

   f. Whether you are currently receiving any benefits as a result of the claim: _____

   g. Identify the name and address of the entity most likely to have records concerning your claim: ___

   h. If applicable, the name and address of your employer against whom the claim was filed:

   _____

XV. FACT WITNESSES

1. Identify all persons whom you believe may possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, phone number, address, and his/her/their relationship to you:

Name	Address and Phone Number	Relationship to You	Information you Believe Person Possesses

XVI. IDENTIFICATION OF DOCUMENTS AND OTHER ELECTRONICALLY STORED INFORMATION

1. For the period beginning three years prior to implantation of the PHS(s) to present, please identify all research, including on-line research, you have conducted regarding the subjects of this litigation, including the implantation of the PHS(s), the injuries and/or damages you claim resulted from the implantation of the PHS(s), or your medical or physical condition. Identify date, time, and source, including any websites visited. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

_____

_____

_____

XVII. DOCUMENT REQUESTS

1. State whether you have any of the following documents in your possession, custody, and/or control. If you do, please separately upload 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.

   ❑Not Applicable

   ❑The documents are attached

   ❑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).

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

c. Produce any communications (sent or received) in your possession, which shall include materials accessible to you from any computer, phone, or smartphone on which you have sent or received such communications, discussing the PHS and/or the additional hernia mesh product(s), your alleged injuries, or subject litigation, including but not limited to all letters, e-mails, blogs, publicly accessible Facebook posts, text messages, tweets, newsletters, etc. sent or received by you. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

❑Not Applicable

❑The documents are attached

❑I have no documents

d. Produce all documents (including journal entries, lists, memoranda, notes, diaries), photographs, medical records, videos, DVDs or other media, including all copies, discussing or referencing the subjects of this litigation including the PHS and/or the additional hernia mesh product(s) or the injuries and/or damages you claim resulted from the PHS and/or the additional hernia mesh product(s) from the date of the implantation of the PHS and/or the additional hernia mesh product(s) to present, including but not limited to the injuries for which you seek relief in this lawsuit. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

❑Not Applicable

❑The documents are attached

❑I have no documents

e. Produce any PHS and/or the additional hernia mesh product packaging, labeling, advertising, or any other PHS and/or the additional hernia mesh product product-related items in your possession, custody or control.

❑Not Applicable

❑The documents are attached

❑I have no documents

f. Produce all documents concerning any communication between you and the Food and Drug Administration (FDA) or between you and any employee or agent of Johnson & Johnson or Ethicon, Inc. regarding the PHS and/or the additional hernia mesh product(s) at issue, except as to those communications which are attorney client/work product privileged.

❑Not Applicable

❑The documents are attached

❑I have no documents

g. To the extent you have documents in your possession identified in response to Question II(12) above, produce such documents.

❑Not Applicable

❑The documents are attached

❑I have no documents

h. Produce any and all documents in your possession, custody or control reflecting, describing, or in any way relating to any instructions or warnings you received prior to implantation of the PHS and/or the additional hernia mesh product(s) concerning the risks and/or benefits associated with the PHS and/or the additional hernia mesh product(s) you received.

❑Not Applicable

❑The documents are attached

❑I have no documents

i. If you underwent surgery to explant in whole or in part the PHS and/or the additional hernia mesh product(s) that you received: produce any and all documents in your possession, custody or control aside from documents that may have been generated by experts retained by your counsel for litigation purposes, relating to any evaluation of the PHS and/or the additional hernia mesh product(s) and any other material that was (were) surgically removed from you.

❑Not Applicable

❑The documents are attached

❑I have no documents

j. If you claim lost wages or lost earning capacity, copies of your federal and state tax returns for the two years prior to implantation of the PHS and/or the additional hernia mesh product(s) to the present.

❑Not Applicable

❑The documents are attached

❑I have no documents in my possession

k. If you claim lost wages or lost earning capacity, copies of all documents supporting that claim.

❑Not Applicable

❑The documents are attached

❑I have no documents in my possession

l. If you are seeking compensation for lost out-of-pocket expenses, copies of all documents supporting that claim.

❑Not Applicable

❑The documents are attached

❑I have no documents in my possession

m. Any photographs, digital images, video, or other media in your possession, custody, or control which show the hernia that was repaired with the PHS and/or the additional hernia mesh product(s) and/or any physical condition or alleged injury you contend was caused by the PHS and/or the additional hernia mesh product(s).

❑Not Applicable

❑The documents are attached

❑I have no documents

n. All documents in your possession, custody or control concerning payment by Medicare on the injured party's behalf relating to the injuries claimed in this lawsuit, including but not limited to Interim Conditional Payment summaries and/or estimates prepared by Medicare or its representatives regarding payments made on your behalf for medical expenses relating to the subject of this litigation.

❑Not Applicable

❑The documents are attached

❑I have no documents in my possession

[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]

SWORN VERIFICATION

By providing the information set forth herein, I declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Plaintiff

_____
Date

SWORN VERIFICATION OF CONSORTIUM PLAINTIFF

By providing the information set forth herein, I declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Consortium Plaintiff

_____
Date

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

The Internal Revenue Service

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 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124**; 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., 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 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102 and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124:** 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, Scherer, Hyland & Perretti LLP; McCarter & English; 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., 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., 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 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962¬1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; Litigation Management, Inc., 6000 Parkland Blvd,. Mayfield Heights, OH 44124; 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
TO RELEASE 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

The Internal Revenue Service

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 furnish and disclose **to Butler Snow, LLP, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124**; 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., 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 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP,**

Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and/or Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124, 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, Scherer, Hyland & Perretti LLP; McCarter & English 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., 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., 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 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124 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").

49950776.v1

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request 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. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov. **Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

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

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My 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:**

_____ _____

_____ _____

_____ _____

***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. We will not disclose records unless you include 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. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

_____

_____

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 § 16.41(d)(2004) 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 seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***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)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

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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 one 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"):

_____
_____
_____

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 _____

Address _____

Name _____

Address _____

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.

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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: _____

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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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application will significantly delay application processing.**

Form **4506**

(Novmeber 2021)

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.

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 $43 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	$
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 completed.

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:
Florida, Louisiana, Mississippi, 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
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, 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.

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.