In Re: Singulair ® Litigation

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

MCL 637

MASTER DOCKET NO. ATL-L-481-22

**CASE MANAGEMENT ORDER #6**
**CASE MANAGEMENT CONFERENCE**
**[PLAINTIFF FACT SHEET]**

THIS MATTER, having been opened to the Court, and the parties having indicated they have no objection to the form and the entry of the within Order; and good cause appearing;

IT IS on this 21st day of December 2022, ORDERED as follows:

The Plaintiff Fact Sheet and authorizations attached hereto as Exhibit A are hereby adopted for use in this litigation.

a. This Order shall govern: (1) all cases transferred to this Court, including those cases subsequently transferred; and (2) all cases directly filed in this MCL.

b. For any case filed or transferred prior to November 30, 2022 ("Group 1 Cases"), Plaintiffs shall serve substantially completed Plaintiff Fact Sheets, executed authorizations, and responsive materials as follows:

   i. Plaintiffs Fact Sheets for sixty (60) cases will be due on or before February 7, 2023.

   ii. Plaintiffs Fact Sheets shall be due for forty-five (45) additional cases on the seventh day of each month thereafter.

c. For cases filed or transferred on or after December 1, 2023, the Plaintiff Fact Sheet, including authorizations and responsive materials shall be due sixty (60) days after the filing of Defendants' Answer.

d. Pursuant to the agreement of the parties, all Plaintiff Fact Sheets, and corresponding authorizations, along with any responsive documentation, shall be completed, signed where applicable, and uploaded to the Singulair Dropbox.

e. Every Plaintiff is required to provide Defendants with a Plaintiff Fact Sheet that is substantially complete in all respects to the best of the Plaintiff's knowledge, answering every question in the Plaintiff Fact Sheet, even if a Plaintiff can answer the questions in good faith only by indicating "not applicable." If a Plaintiff is suing in a representative or derivative capacity, the Plaintiff Fact Sheet shall be completed by the person with the legal authority to represent the estate or person under legal disability.

f. The Plaintiff Fact Sheet shall be completed without objections as to the questions posed in the agreed upon 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 simultaneously with the submission of the Plaintiff Fact Sheet.

g. Contemporaneous with submission of the Plaintiff Fact Sheet, each Plaintiff shall transmit via email or other FTP upload, copies or electronic files of all medical records in their possession, custody, or control (including any medical records in their attorney's possession) related to the claims and/or alleged injuries in their case, including, but not limited to, records that support product identification.

h. Contemporaneous with submission of the Plaintiff Fact Sheet, each Plaintiff shall upload to the Singulair Dropbox, signed authorizations, which are attached to the Plaintiff Fact Sheet.

i. The signed authorizations shall be undated, and the recipient line shall be left blank. These blank, signed authorizations constitute permission for a third-party records vendor retained by the Defendants to obtain records from the healthcare providers, pharmacies, employers, and schools specified in the responses to the Plaintiff Fact Sheet from the records custodians. In the event an institution, agency, or medical provider to which a signed authorization is presented refuses to provide responsive records, the individual Plaintiff's attorney agrees to

cooperate with Defense Counsel to attempt to resolve the issue with the institution, agency, or medical provider such that the necessary records are promptly provided, including obtaining a revised authorization, if necessary. Defendants have the right to use the authorizations to obtain records from custodians not identified in the Plaintiff Fact Sheet but only if authorized by Plaintiff's counsel. Plaintiff's counsel will respond to any such request within seven (7) business days of the request and authorization should be afforded absent good cause. The authorizations provided by Plaintiff become null and void when his or her case is resolved, and any use of the authorizations beyond that date is prohibited.

j. The Plaintiff Fact Sheet will not be interpreted to limit the scope of inquiry at depositions, nor will it affect whether evidence is admissible at trial. The admissibility of information in the Plaintiff Fact Sheet is governed by the New Jersey Rules of Evidence, and objections to admissibility are not waived by virtue of the completion and service of a Plaintiff Fact Sheet.

k. Plaintiff is under a continuing obligation to timely supplement or amend Plaintiff Fact Sheets and responsive documentation.

l. 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 21 days before the date of Plaintiff's deposition. If the Plaintiff's deposition is set to occur in less than 21 days from the time it is scheduled, then Plaintiff shall submit any such supplements and/or amendments as soon as practicable but no less than 5 business days before the date of the Plaintiff's deposition.

m. Any Plaintiff who fails to fully comply with the requirements above shall be provided notice of such failure by email from Defendants' Counsel to all counsel of record on the case and shall be provided 28 additional days to cure such deficiency ("Cure Period") to be calculated from the date following transmission of the email from Defense Counsel. If Defendants' notice of failure is related to a deficiency regarding information provided in the Plaintiff Fact Sheet, as opposed to Plaintiff's failure to provide a Plaintiff Fact Sheet whatsoever, Defendants shall

state with particularity in Defendants' notice to Plaintiff why Defendants believe the information in the Plaintiff Fact Sheet is deficient. Defendants shall also be required to make themselves available by email or phone to meet-and-confer to clarify any alleged information deficiencies.

n. Any Request for an extension of time to serve the Plaintiff Fact Sheet, authorizations, and responsive documents and/or any request for an extension of the deficiency Cure Period should be submitted to Defendants via email to SingulairMCL_POU@Venable.com.

o. If a Plaintiff fails to cure a deficiency within the Cure Period set forth in section l. above, Defendants may seek permission to file a Motion to Compel (if Plaintiff Fact Sheet information is deficient) or a Motion to Dismiss (if Plaintiff has failed to provide a Plaintiff Fact Sheet).

p. Plaintiff shall thereafter have 14 days to file a Response to the Motion and show good cause why the information is sufficient, the case should not be dismissed, and/or why less drastic sanctions other than dismissal are warranted. Defendants may file a Reply Brief within 7 days of Plaintiff's Response.

q. This Case Management Order shall apply to each member related case previously transferred to or filed in this Court. In cases subsequently filed in this Court, it shall be the responsibility of the Parties to review and abide by all pretrial Orders previously entered by the Court. The Orders may be accessed through the New Jersey State Court Electronic Filing System.

r. This order supersedes Case Management Order 2 to the extent it addresses proof of use.

The Honorable John C. Porto, P.J. Civ.

# EXHIBIT A

**SUPERIOR COURT OF NEW JERSEY**
**LAW DIVISION: ATLANTIC COUNTY**

| | | |
|---|---|---|
| IN RE: SINGULAIR LITIGATION | * | MCL NO. 637 |

**********

## PLAINTIFF FACT SHEET

In completing this Plaintiff Fact Sheet, you must provide information regarding yourself or each individual on whose behalf a personal injury claim is being made that is true and correct to the best of your knowledge. The Plaintiff Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

Please attach as many sheets of paper as necessary to fully answer these questions.

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

(1) "**health care provider**" or "**health care practitioner**" means any hospital, clinic, center, physician's office, dentist's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, oral, psychiatric, mental, emotional, or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, dentist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, dental, oral, radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of you.

(2) "**Singulair**" means the brand name product, SINGULAIR®.

(3) **"montelukast"** means the generic drug, montelukast.

(4) "**you**" refers to the person who used Singulair, unless otherwise specified.

(5) **"Merck"** refers to Merck & Co, Inc. and Merck, Sharp & Dohme Corp.

If you are completing this PFS in a representative capacity on behalf of someone who has died or who otherwise cannot complete the PFS, please answer as completely as you can for that person. Those questions using the term "you" refer to the person whose treatment involved the use of Singulair or montelukast. If the individual is deceased, please respond as of the time immediately before his or her death unless a different time period is specified.

## I. CASE INFORMATION

A. Caption: _____

B. Docket No: _____

C. Primary Attorney Contact (name, address, phone, and email): _____

_____

D. If you are completing this questionnaire on behalf of someone else (*e.g.*, a deceased person, a minor, or an incapacitated person), please complete the following:

1. Your name: _____
2. Your address: _____
3. The capacity in which you are representing this individual: _____

_____

4. If you were appointed by a court, please provide a copy of the order of appointment or power of attorney/authorizing document, and state the:
   a. Court: _____
   b. Date of appointment: _____
5. Your relationship to the deceased or represented person: _____

_____

6. If you represent a decedent's estate, the date of death: _____
7. If you represent a minor, did you consult with the minor when filling out this form? _____

## II. PERSONAL INFORMATION OF THE PERSON WHO USED SINGULAIR

A. Name: _____

B. Maiden name(s) or any other name(s) by which you have been known (from prior marriages or otherwise, if any): _____

_____

C. Gender: Male _____ Female _____

D. Social Security Number: _____

E. Date of Birth: _____

F. Place of Birth (City, County, and State): _____

G. Current and/or Prior Spouse's Name: _____

1. If applicable, has your spouse filed a loss of consortium claim in this action? Yes _____ No _____

H. Identify each school (including grade school and high school), college, university, and other educational institutions you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded (add rows as necessary):

| Educational Institution (Name and Address) | Dates of Attendance | Courses of Study | Diplomas/Degrees Awarded |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I. Provide the following information with respect to your employment for the last twenty (20) years (add rows as necessary):

| Employer | Address | Occupation/Job Duties | Dates of Employment | Reasons for Leaving | Salary/Bonus/ Overtime |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

J. Have you ever served in any branch of the U.S. Military? Yes___ No ___

**If "yes,"** please identify:

1. Branch, rank and dates of service: _____

   _____
2. Type and manner of discharge:_____
3. Last four duty stations: _____

   _____
4. Are you retired from military service? Yes ___ No ___

**III. CLAIM INFORMATION [If you are alleging multiple injuries, answer all questions to Section III.B for each injury you allege]**

A. Do you claim that you have suffered any physical, neurological, psychological, psychiatric and/or emotional injury as a result of Singulair use?

Yes _____ No _____

B. If the answer to the foregoing question is "yes," identify the injury or injuries that you claim are related to your Singulair use, including all diagnoses that have been provided for your injury.:

_____

_____

_____

_____

1. When do you claim this injury first occurred?

_____
(month/day/year)

2. Approximately when did you first become aware of the symptoms arising from the injury identified above? _____

_____

3. If the injury was diagnosed by a health care provider, provide the date of diagnosis: _____
(month/date/year)

C. Are you making a claim for lost wages for either your present or previous employment (meaning that you lost time from work because of the injuries caused by Singulair or montelukast)? Yes _____ No _____

1. If you answered "Yes," please provide:

a. The name of your employer(s) when you missed work:_____

b. The amount of time you missed from work: _____

c. The identity of any health care provider(s) who recommended that you miss work _____

D. Are you making a claim for lost earning capacity (meaning that you would be able to get better jobs if you had not suffered the injury caused by Singulair or montelukast)? Yes____ No_____

1. If you answered "Yes," please provide:

a. The jobs you claim you would have obtained but for the injury

_____

b. The employers who you claim would have provided those jobs

_____

E. Claim Information

1. Have you ever filed a workers' compensation claim? Yes ___ No ___

**If "yes,"** please state:

a. Year claim was filed: _____

b. Nature of disability: _____

c. Approximate date(s) of disability: _____

d. Resolution of claim: Denied ____ Granted ____ Other ____

**If "other,"** please describe: _____

_____

e. Full name and address of your employer against whom your claim was filed: _____

_____

2. Have you ever filed a social security disability (SSI or SSD) claim?

Yes ____ No ____

**If "yes,"** to the best of your knowledge please state:

a. Year claim was filed: _____

b. Nature of disability: _____

c. Approximate dates of disability: _____

d. Resolution of claim: Denied ____ Granted ____ Other ____

**If "other,"** describe: _____

_____

F. For each insurance company or other entity (including government healthcare programs such as Medicare, Medicaid, Tricare and other similar programs) that has provided medical and/or dental coverage to you (either directly or through a group or employer) for the period beginning seven (7) years before your first use of Singulair through the present, please identify the following information:

| Insurance Company Name and Address | Policy/Account Number | Policy Holder | Approximate Dates of Coverage |
|---|---|---|---|
| | | | |
| | | | |

| Insurance Company Name and Address | Policy/Account Number | Policy Holder | Approximate Dates of Coverage |
|---|---|---|---|
| | | | |

## IV. FAMILY INFORMATION

A. Have your parents, siblings, or children ever had or been diagnosed with psychologic or psychiatric disorders (*e.g.*, anxiety, depression, suicidality, etc.)? Yes _____ No _____

**If "yes,"** state (1) the name of the individual, (2) the relationship of the person to you, (3) the disorder(s) he or she has/had, and (4) the date of that individual's diagnosis (add rows as necessary):

| Name of Relative | Relationship to You | Disorder(s) | Date of Diagnosis(es) |
|---|---|---|---|
| | | | |
| | | | |

## V. MEDICAL BACKGROUND AND INFORMATION

A. Have you ever had suicidal thoughts or attempted suicide at any point in time in the past? Yes _____ No _____

**If "yes,"** please identify the date, dates, or time period during which you had such thoughts or attempts and identify any health care providers who treated you as a result, including addresses and dates of treatment: _____

_____

_____

B. Have you ever engaged in an act of self-harm or self-mutilation at any point in time in the past? Yes _____ No _____

**If "yes,"** please identify the date, dates, or time period during which you engaged in such acts and identify any health care providers who treated you as a result, including addresses and dates of treatment: _____

_____

_____

C. Have you ever been hospitalized for any mental health or psychiatric reason at any point in time in the past? Yes _____ No _____

**If "yes,"** please identify the date, dates, or time period during which you were hospitalized, the name and address of the hospital, and the condition for which you were treated: _____

_____

_____

D. Have you ever experienced, or have you ever been treated for (whether with medication, counseling, or other therapy, and whether in a hospital, outpatient, or other clinical setting) any other mental health, psychological, psychiatric, or emotional problem (including depression or anxiety) Yes _____ No _____

**If "yes,"** please provide the following information for each condition:

1. Describe the symptoms experienced: _____

_____

_____

2. Identify the date of onset of each condition and the duration of the condition: _____

_____

_____

3. Please provide the name, address, telephone number, and specialty of the person who provided the diagnosis and/or treatment: _____

_____

_____

4. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____

_____

_____

E. For each provider of care identified in paragraphs A-D, please produce an executed copy of the release form attached as Exhibit A, authorizing Merck to obtain your psychiatric, psychological, mental health, and psychotherapy notes and related records generated by any such mental health care practitioner.

## VI. SINGULAIR AND OTHER MEDICATION USE

A. For every drug you used, including Singulair, from seven years before you started taking Singulair through the present, please fill out this chart (please add rows if necessary):

| Name of Drug | Dates of Use of Drug (month/day/year) | Dosage and Form of Dose | Full Name of Physician(s) Who Prescribed | Full Address of Prescribing Physician(s) | Condition(s) Treated |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

B. Provide the following information for any pharmacy or pharmacies (including mail order or internet pharmacies) where a prescription for each drug identified above was filled (add rows as necessary):

| Name of Drug | Name of Pharmacy | Address of Pharmacy | Rewards Account Number |
|---|---|---|---|
| | | | |
| | | | |

C. At any time, did you see any written, televised or internet-based advertising or labeling materials regarding Singulair?

Yes _____ No _____

**If "yes,"** state: which written, televised or internet-based advertising or labeling materials you recall seeing regarding Singulair; from what source you saw such advertising or labeling materials; and when you saw such advertising or labeling materials, excluding any such materials that are covered by the Attorney-Client or Work Product Privileges: _____

_____

## VII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

***For Every Hospital or Healthcare Provider You Have Not Already Identified on This Form, Identify:***

A. Each hospital, clinic, or healthcare facility where you have received inpatient treatment (or been admitted as a patient), outpatient treatment, or treatment in an emergency room during the seven (7) years prior to the date of your first use of Singulair through the present (add rows as necessary):

| Name | Address | Date(s) of Admission | Reason(s) for Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

B. Each healthcare provider by whom you have been seen or from who you have received treatment at any time during the seven (7) years prior to the date of your first use of Singulair or any other leukotriene inhibitor through the present (add rows as necessary):

| Name | Address | Reason for Treatment | Approximate Date(s) of Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## VIII. AUTHORIZATIONS

Please produce an executed copy of the release forms identified as Exhibits A, B, C, D, E, F, G, H and I that are attached to this PFS.

## CERTIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge and I have supplied the authorizations attached to this declaration.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Print Name | Date |

# EXHIBIT A

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
**(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)**

TO: _____

Patient Name: _____

DOB: _____

SSN: _____

I,_____, hereby authorize you to release and furnish to: Litigation Management Inc., PO Box 241370, Cleveland, OH 44124 COPIES ONLY of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All reports of autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants and has been approved by the Court supervising this litigation. This authorization is for the sole purpose of allowing copies of my medical records to be provided to the defendants in this litigation. It does not allow discussions of my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition.

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may

inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____(plaintiff/representative)

Signature: _____ _____
Date

**AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS**

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all forms regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, records, notes or invoices and bills, which may be in your possession.

_____
*Name of Insured*

whose date of birth is _____ and whose social security number is: _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requester
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof, it is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

_____ _____
Name/Signature Date

**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;

Social Security Administration; and

Department of the Treasury/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 Litigation Management, Inc. PO Box 241370, Cleveland, OH 44124 and its 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: _____ _____ _____

- 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 Litigation Management (PO Box 241370, Cleveland, 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 redisclosure 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 Litigation Management, Inc, pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ _____ and is subject to redisclosure 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 _____ (ii) one (1) year 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 Litigation Management, Inc. PO Box 241370, Cleveland, OH 44124, and its authorized representatives, by any entities included in the categories listed above.**

Date:_____ _____

Signature of Individual or Individual's Representative

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

_____

Relationship of Representative to 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").

# MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

## SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

| First Name: | Middle Name: | Last Name: |
|---|---|---|
| Date of Birth *(mm/dd/yyyy)* | Medicare Identification Number: | |
| Address: | | |
| City: | State: | Zip code: |

## SECTION B: RECORD DETAILS DEFINITION

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:
- ☐ Release **all** records to date
- ☐ Release records in timeframe from start date _____ to end date: _____

**NY residents only:**
- ☐ Include all records
- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or Identify a future date or event when the authorization will expire.

Select **one** option:
- ☐ One-time disclosure
- ☐ Expiration upon specified date _____
- ☐ Expiration upon specified event _____

## SECTION C: RELEASE INFORMATION TO

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

Release claim records to beneficiary at mailing address above.

| Organization/Individual 1 Name | Recipient 1 Email Address |
|---|---|
| Recipient 1 Mailing Address: | |

## SECTION D: PURPOSE FOR REQUEST

This section helps Medicare understand the reason or intent for use for this record request.

| At the request of the individual | Litigation |
|---|---|

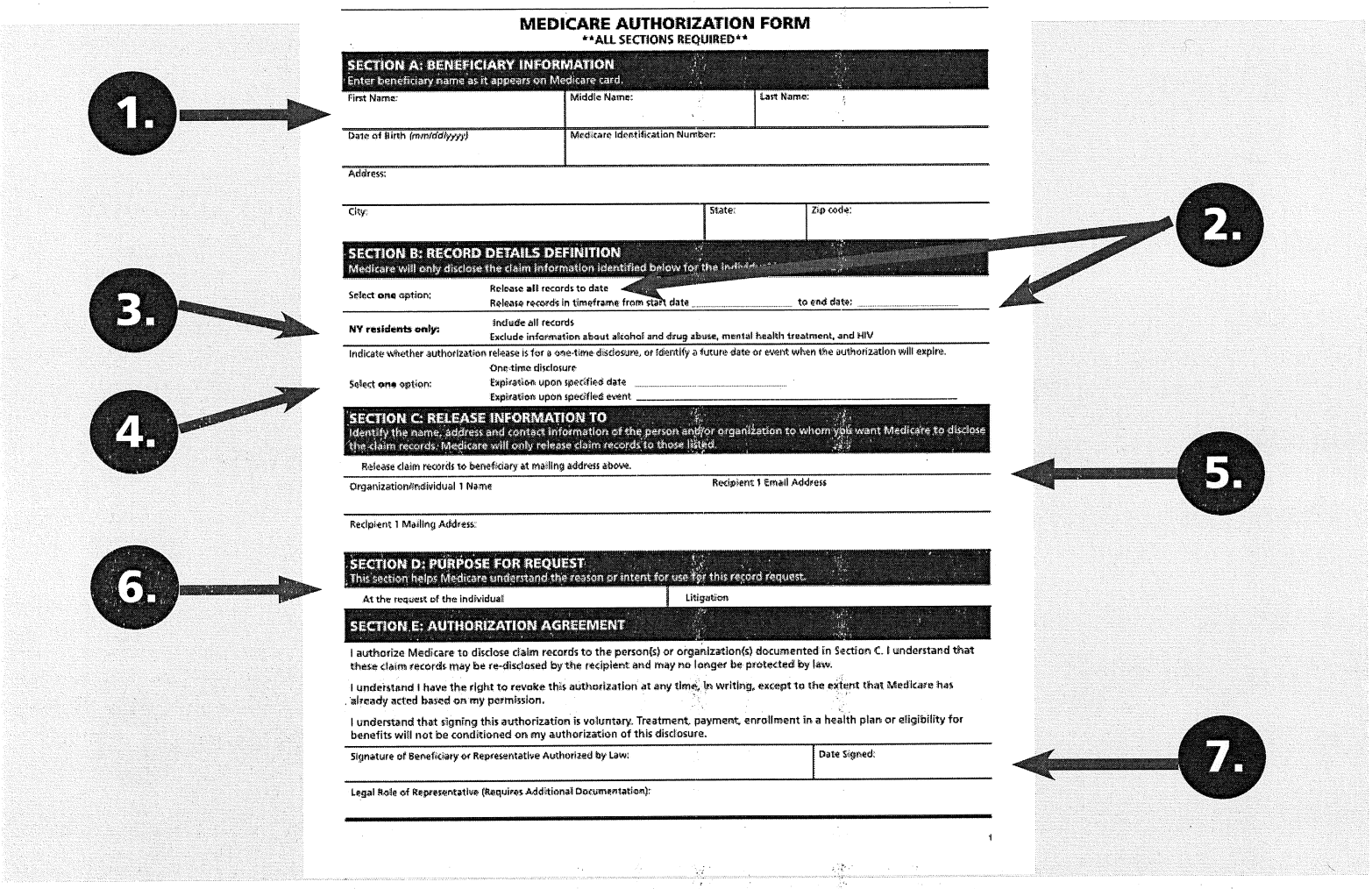
## SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

| Signature of Beneficiary or Representative Authorized by Law: | Date Signed: |
|---|---|
| Legal Role of Representative (Requires Additional Documentation): | |




1. **BENEFICIARY INFORMATION**
   Add beneficiary name and ID number as printed on Medicare identification card, date of birth, and address.
2. **RECORD TIMEFRAME**
   Indicate date range of records to release, or select "release all records."
3. **NY RESIDENTS: EXCLUSIONS OPT-IN**
   **(NY residents only)** Specify whether to exclude records related to alcohol and drug abuse, mental health treatment, and HIV.
4. **SELECT EXPIRATION DATE OR EVENT**
   Indicate date or event information release authorization will expire, if you are not requesting a one-time disclosure.
5. **SPECIFY ORGANIZATION TO RELEASE TO**
   Specify individual(s) to whom records should be released. First name, last name, and address are required. Additional contact information provided will be used only to follow up on questions related to your application submission.
6. **SELECT REASON FOR REQUEST**
   Select purpose for record release request to help Medicare understand how records will be used.
7. **BENEFICIARY SIGNATURE**
   Signature and date by beneficiary or authorized representative in acceptance of HIPAA clauses required to release information. If form not signed by beneficiary, attach notarized Power of Attorney (living individual), or Letters Testamentary and/ or Letters of Administration from the court (deceased individual).

# EXHIBIT B

**Department of Veterans Affairs**

# REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

**PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION:** The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

| LAST NAME- FIRST NAME- MIDDLE NAME | DATE OF BIRTH *(mm/dd/yyyy)* |
|---|---|
| | |

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

**PURPOSE(S) OR NEED**: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

**INFORMATION REQUESTED:** Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

| LAST NAME- FIRST NAME- MIDDLE NAME | DATE OF BIRTH *(mm/dd/yyyy)* |
|---|---|
| | |

**SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.**

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

**EXPIRATION:** Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

| PATIENT SIGNATURE *(Sign in ink)* | DATE *(mm/dd/yyyy)* |
|---|---|
| | |

| LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)* | DATE *(mm/dd/yyyy)* |
|---|---|
| | |

| PRINT NAME OF LEGAL REPRESENTATIVE | RELATIONSHIP TO PATIENT |
|---|---|
| | |

**FOR VA USE ONLY**

TYPE AND EXTENT OF MATERIAL RELEASED

| DATE RELEASED *(mm/dd/yyyy)* | RELEASED BY: |
|---|---|
| | |

# EXHIBIT C

# AUTHORIZATION FOR RELEASE OF EDUCATIONAL RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all school records including, but not limited to, test results, test scores, report cards, or other school grading material, attendance records, physicals and other health-related, including but not limited to any physicians, nursing or allied health professional reports, records or notes, which may be in your possession.

_____
*Name of Student*

whose date of birth is _____ and whose social security number is: _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requester
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____
Student/Name

# EXHIBIT D

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:** |
|---|---|
| LITIGATION MANAGEMENT, INC. | 6000 PARKLAND BOULEVARD |
| | MAYFIELD HEIGHTS, OH 44124 |

***I want this information released because:** to be used in support of an active litigation.
We may charge a fee to release information for non-program purposes.

Invoices can be sent via fax to: 440-484-2055, please reference the PacketID number found above Social Security Disability on the request letter.

Please feel free to contact Litigation Management, Inc. directly at (888) 803 - 8706 with any questions.

***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 PRESENT.
5. ☒ My Medicare entitlement from date _____ to date PRESENT.
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.)

   Documents or other items relating to my social security claims(s): applications, questions, petitions, payment documents/decisions/awards/denials, jurisdictional documents/notes, transcripts, correspondence, findings, notice of hearings, hearing records, orders, depositions, reports; witnesses, medical reviewers and experts consultative examination reports, current developments/temporary, non-disability development and documentation, medical records and determination records.

**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) |

**HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508**
**WORKERS' COMPENSATION AUTHORIZATION**

TO: _____

RE: Name: _____ aka _____

Date of Birth: _____Social Security Number: _____

Address: _____

I authorize the disclosure of my Workers' Compensation records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to _____.

I authorize you to release the information to Litigation Management Inc., P.O. Box 241370, Cleveland, OH 44124.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I further

acknowledge that information about HIV/AIDS and alcohol/substance abuse may be disclosed. I also understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires _____ or at the conclusion of the case, whichever occurs first.

**Print Name:** _____ **(plaintiff/representative)**

**Signature:** _____ **Date:** _____

# EXHIBIT E

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.
**Litigation Management Inc, 6000 Parkland Blvd, Mayfield Heights, OH 44124 888-803-8706**

**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. ▶ **1040**

**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<br>RAIVS Team<br>Stop 6716 AUSC<br>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<br>RAIVS Team<br>Stop 6705 S-2<br>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<br>RAIVS Team<br>P.O. Box 9941<br>Mail Stop 6734<br>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<br>RAIVS Team<br>Stop 6705 S-2<br>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<br>RAIVS Team<br>P.O. Box 9941<br>Mail Stop 6734<br>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.

**AUTHORIZATION TO DISCLOSE TAX RETURNS INFORMATION**

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **Litigation Management, Inc.** any and all records containing Tax information, regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all tax returns, attachments to tax returns, forms, schedules, correspondence, and any statements, communications, reports, questionnaires, and records submitted, and any and all other documents and writings of any kind.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above firms. A copy of this authorization may be used in place of and with the same force and effect as the original. This authorization expires one year after it is signed.

_____
Personal Representative

_____
Date

_____
Name

_____
Former/Alias/Maiden Name

_____
Date of Birth Date of Death

_____
Social Security Number

_____
Address

# EXHIBIT F

Form **SSA-7050-F4** (02-2021)
Discontinue Prior Editions
Social Security Administration


OMB No. 0960-0525

# REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

*Use This Form If You Need

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

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

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

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

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

## Privacy Act Statement
## Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, allows us to collect this information. In addition, the Budget and Accounting Act of 1950 and Debt Collection Act of 1982 authorize us to collect credit card information, if you choose to pay for the earnings information you have requested with a credit card. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from processing your request.

We will use the information to identify your records, process your request, and send the earnings information you request. We may also share the information for the following purposes, called routine uses:

1. To the Internal Revenue Service (IRS) for auditing SSA's compliance with the safeguard provisions of the Internal Revenue Code of 1986, as amended.

2. To contractors and other Federal agencies, as necessary, for the purpose of, assisting the Social Security Administration (SSA) in the efficient administration of its programs.

3. To banks enrolled in the Treasury credit card network to collect a payment or debt when the individual has given his/her credit card number for this purpose.

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 (SORNs) 60-0059, entitled Earnings Recording and Self-Employment Income System, 60-0090, entitled Master Beneficiary Record, 60-0224, entitled SSA-Initiated Personal Earnings and Benefit Estimate Statement, and 60-0231, entitled Financial Transactions of SSA Accounting and Finance Offices. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

**Paperwork Reduction Act Statement -** This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

Form **SSA-7050-F4** (02-2021) 

# REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

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

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) One SSN per request

Date of Birth: Date of Death:

Other Name(s) Used
Maiden Name

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

☐ **Itemized Statement of Earnings $92.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

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

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $30.00 fee.

☐ **Certified Yearly Totals of Earnings $30.00**
(Does not include the names and addresses of employers)Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

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

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

| | | |
|---|---|---|
| Name | Litigation Management, Inc. | |
| Address | PO Box 241370 | State OH |
| City | Cleveland | ZIP Code 44124 |

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

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

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

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

# EXHIBIT G

**HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508**
**EMPLOYMENT AUTHORIZATION**

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name: _____ aka _____

Date of Birth: _____Social Security Number: _____

Address: _____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of alt applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews and reports; transfers, statements and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s, worker's compensation files; all medical records, x- rays and test results; any physical examination records; all documents relating to my absences, illnesses and injuries; any records pertaining to claims made relating to health, disability or accidents in which 1 was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file.
Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I authorize you to release the information to;

_____
Name (Records Requestor)

_____
Street Address City State and Zip Code

I intend that this authorization shall be continuing in nature. If information responsive to this

authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not i sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires _____ or at the conclusion of the case, whichever occurs first.

_____

Signature of Employee or Personal Representative Date Name of Employee or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

# EXHIBIT H

# INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

**1. General Information.** The Standard Form 180, Request Pertaining to Military Records (SF 180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF 180 for record locations and facility addresses. Medical information may be withheld from a patient if determined that the information would be detrimental to the patient's physical or mental health or would likely cause the patient to harm himself or someone else.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next-of-kin using eVetRecs at http://www.archives.gov/veterans/military-service-records/.

**2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR).** Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180 (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago).

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's authorized legal recipient has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's authorized legal recipient is needed in Section III of the SF 180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or authorized legal recipient. If the appropriate signature cannot be obtained, only limited types of information can be provided (DoD 6025.18-R C8). If the former member is deceased, the surviving next-of-kin (NOK) may be entitled to greater access to a deceased veteran's records than a member of the general public (DoD 6025.18-R C6.2.1.2). The NOK may be any of the following: unmarried/surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death, such as the DD Form 1300, Casualty Report, a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

b. Fees for records: There is no charge for most services provided to service members or next-of-kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances, service fees cannot be determined in advance. If your request involves a service fee, you will receive an invoice with your records.

**3. Archival Records.** Personnel records of military members who were discharged, retired, or died in service **62 OR MORE YEARS AGO** have been transferred to the legal custody of NARA and are referred to as "archival records".

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next-of-kin is not required. In order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and may preclude the release of some information.

b. Fees for Archival Records: Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the copies of documents in the requested record, you will receive an invoice. Copies will be sent after payment is made. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

**4. Where reply may be sent.** The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number. NOTE: If requester desires to send his/her record to a third party, he/she must fill out a DD Form 2870 authorizing the releasing agency to release the record and the timeframe of the authorization. The form may be downloaded using most commercial web search tools by entering "DD Form 2870" as a search term.

**5. Definitions and abbreviations.** DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health, and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

**6. Service completed before World War I.** National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

## PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

## PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (MP), 8601 Adelphi Road, College Park, MD 20740-6001. *DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.* SEND COMPLETED FORMS TO THE APPROPRIATE ADDRESS LISTED ON PAGE 2 OF THE SF 180.

Standard Form 180 (Rev. 4/2021) (Page 1)
Prescribed by NARA (36 CFR 1233.18 (d))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2024

# REQUEST PERTAINING TO MILITARY RECORDS

**Requests can be submitted online using eVetRecs at http://www.archives.gov/veterans/military-service-records/**

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

## SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

| 1. NAME USED DURING SERVICE (last, first, full middle) | 2. SOCIAL SECURITY # | 3. DATE OF BIRTH | 4. PLACE OF BIRTH |
|---|---|---|---|
| | | | |

**5. SERVICE, PAST AND PRESENT** *(For an effective records search, it is important that ALL service be shown below.)*

| | BRANCH OF SERVICE | DATE ENTERED | DATE RELEASED | OFFICER | ENLISTED | SERVICE NUMBER (If unknown, write "unknown") |
|---|---|---|---|---|---|---|
| a. ACTIVE | | | | ☐ | ☐ | |
| b. RESERVE | | | | ☐ | ☐ | |
| c. NATIONAL GUARD | | | | ☐ | ☐ | |

**6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN:** 1. _____ 2. _____ 3. _____ 4. _____

**7. IS THIS PERSON DECEASED?** ☐ NO ☐ YES - ***MUST** provide Date of Death if veteran is deceased:* _____

**8. DID THIS PERSON RETIRE FROM MILITARY SERVICE?** ☐ NO ☐ YES

## SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

**1. CHECK THE ITEM(S) YOU ARE REQUESTING:**

☐ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation):_____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
***An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box:*** ☐ I want a **DELETED** copy.

☐ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.

☐ I request inpatient/hospitalization records from _____(facility), last treated in _____(year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

**2. PURPOSE:** (Providing information about the purpose of the request is **voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

## SECTION III - RETURN ADDRESS AND SIGNATURE

**1. REQUESTER NAME:** _____

**2. RELATIONSHIP TO VETERAN:** _____

**3.** ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.
☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)
☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)
☐ OTHER (Specify): _____

**4. SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 4 on accompanying instructions.)

Name _____

Street Address _____ Apt. # _____

City _____ State _____ ZIP Code _____

Daytime Phone _____ Fax Number _____

Email Address _____

**5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information.** *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

**Signature Required** – Do not print _____ **Date** _____

* This form is available at http://www.archives.gov/veterans-military-service-records/standard-form-180.pdf on the National Archives and Records Administration (NARA) web site. *

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

| BRANCH | CURRENT STATUS OF SERVICE MEMBER | Personnel Record | Medical or Service Treatment Record |
|---|---|---|---|
| AIR FORCE | Discharged, deceased, or retired before 5/1/1994 | 14 | 14 |
| | Discharged, deceased, or retired 5/1/1994 – 9/30/2004 | 14 | 11 |
| | Discharged, deceased, or retired 10/1/2004 – 12/31/2013 | 1 | 11 |
| | Discharged, deceased, or retired on or after 1/1/2014 | 1 | 13 |
| | Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay | 1 | |
| | Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force | 2 | |
| | Current National Guard enlisted not on active duty in the Air Force | 2 | 13 |
| COAST GUARD | Discharged, deceased, or retired before 1/1/1898 | 6 | |
| | Discharged, deceased, or retired 1/1/1898 – 3/31/1998 | 14 | 14 |
| | Discharged, deceased, or retired 4/1/1998 – 9/30/2006 | 14 | 11 |
| | Discharged, deceased, or retired 10/1/2006 – 9/30/2013 | 3 | 11 |
| | Discharged, deceased, or retired on or after 10/1/2013 | 3 | 14 |
| | Active, Reserve, Individual Ready Reserve or TDRL | 3 | |
| MARINE CORPS | Discharged, deceased, or retired before 1/1/1895 | 6 | |
| | Discharged, deceased, or retired 1/1/1905 – 4/30/1994 | 14 | 14 |
| | Discharged, deceased, or retired 5/1/1994 – 12/31/1998 | 14 | 11 |
| | Discharged, deceased, or retired 1/1/1999 - 12/31/2013 | 4 | 11 |
| | Discharged, deceased, or retired on or after 1/1/2014 | 4 | 8 |
| | Individual Ready Reserve | 5 | |
| | Active, Selected Marine Corps Reserve, TDRL | 4 | |
| ARMY | Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer) | 6 | |
| | Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer) | 14 | |
| | Discharged, deceased, or retired 10/16/1992 – 9/30/2002 | 14 | 11 |
| | Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013 | 7 | 11 |
| | Discharged, deceased, or retired (including TDRL) on or after 1/1/2014 | 7 | 9 |
| | Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard) | 7 | |
| NAVY | Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer) | 6 | |
| | Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer) | 14 | 14 |
| | Discharged, deceased, or retired 1/31/1994 – 12/31/1994 | 14 | 11 |
| | Discharged, deceased, or retired 1/1/1995 – 12/31/2013 | 10 | 11 |
| | Discharged, deceased, or retired on or after 1/1/2014 | 10 | 8 |
| | Active, Reserve, or TDRL | 10 | |
| PHS | Public Health Service - Commissioned Corps officers only | 12 | |

**ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form**

| | | | | | |
|---|---|---|---|---|---|
| 1 | Air Force Personnel Center<br>AFPC/DP2SSM<br>550 C Street West<br>JBSA-Randolph TX 78150-4721<br>Fax: 210-565-3124<br>Email:<br>DP2SSM.MILRECS.INCOMING@US.AF.MIL | 6 | National Archives & Records Administration Research Services (RDT1R)<br>700 Pennsylvania Avenue<br>NW Washington, DC<br>20408-0001 | 11 | Department of Veterans Affairs<br>ATTN: Release of Information<br>Claims Intake Center<br>P.O. Box 4444<br>Janesville, WI 53547-4444<br>Fax: 844-531-7818<br>https://www.va.gov |
| 2 | Air Reserve Personnel Center<br>Total Force Service Center: 1-800-525-0102<br>https://mypers.af.mil/ | 7 | US Army Human Resources Command's web page:<br>*https://www.hrc.army.mil/content/1113*<br>or 1-888-ARMYHRC (1-888-276-9472) | 12 | Division of Commissioned Corps Officer Support<br>ATTN: Records Officer<br>1101 Wooton Parkway, Plaza Level, Suite 100<br>Rockville, MD 20852 |
| 3 | Commander, Personnel Service Center<br>(BOPS-C-MR) MS7200<br>US Coast Guard<br>2703 Martin Luther King Jr Ave SE<br>Washington, DC 20593-7200<br>https://www.dcms.uscg.mil/ompf | 8 | Navy Medicine Records Activity<br>(NMRA) BUMED Detachment St. Louis<br>4300 Goodfellow Boulevard, Building<br>103 St. Louis, MO 63120<br>Fax number: 314-260-8128 | 13 | AF STR Processing Center ATTN:<br>Release of Information 3370<br>Nacogdoches Road, Suite 116<br>San Antonio, TX 78217 |
| 4 | Headquarters U.S. Marine Corps<br>Manpower Management Records & Performance<br>(MMRP-10)<br>2008 Elliot Road<br>Quantico, VA 22134-5030<br>SMB.MANPOWER.MMRP-10@usmc.mil | 9 | AMEDD Army Record Processing Center<br>3370 Nacogdoches Road, Suite 116<br>San Antonio, TX 78217<br>Fax Number: 210-201-8310 | 14 | National Personnel Records Center<br>(Military Personnel Records)<br>1 Archives Drive<br>St. Louis, MO 63138-1002<br>*http://www.archives.gov/veterans/military-service-records/* |
| 5 | Marine Corps Forces Reserve<br>2000 Opelousas Avenue<br>New Orleans, LA 70114 | 10 | Navy Personnel Command (PERS-313) 5720 Integrity Drive<br>Millington, TN 38055-3130 | | |

# EXHIBIT I

Walgreens

**Walgreens Custodian of Records, 1901 East Voorhees Street, MS 735, Danville, Illinois 61834**
**Fax: (217) 554-8955 Phone: (217) 554-8949**

## REQUEST TO ACCESS, INSPECT, OR OBTAIN PROTECTED HEALTH INFORMATION

**Request:**

I request to review health information held about me in the Walgreens "designated record set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that Walgreens has 30 days to respond to this request, Walgreens may extend this 30 day response period for another 30 days, and in certain circumstances Walgreens may deny my request.

**Information:**

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip _____

Telephone Number: (___) _____ E-mail Address: _____

Standard requests for records contain a fifteen (15) month time period. If your request for records is in excess of fifteen (15) months, please indicate the time frame below. Records are retained in accordance with State Board of Pharmacy, DEA, and other relevant laws and vary from state to state.

From: _____ To: _____

I further request that my health information is directed to the third party at the address designated below.

Third Party Recipient : _____
Relationship: _____
Street Address: _____
City, State, Zip _____

Telephone Number: (___) _____ E-mail Address: _____

**Agreement:**

I agree that Walgreens may provide a summary of health information instead of allowing me to review the information (check response below):

☐ Yes ☐ No Fee for Summary: _____

I agree to pay any fees for copying or summarizing my health information. Fees will be reasonable and cost-based, and include only the cost of copying, postage, and preparation of a summary (if I agree to a summary).

I understand that this request does not apply to certain health information, including: (1) information that is not held in the designated record set; (2) information compiled in reasonable anticipation of or for litigation; and (3) other information not subject to the right to access information under HIPAA.

**Signature:**

Signature: _____ Date: _____

Walgreens

**Walgreens Custodian of Records, 1901 East Voorhees Street, MS 735, Danville, Illinois 61834**
**Fax: (217) 554-8955 Phone: (217) 554-8949**

**If signed by the patient's personal representative, explain authority to act on behalf of the patient:**

Note: If you are signing this form as the legal representative of the individual listed above, and are other than the parent of the minor child whose information is listed above, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

_____

_____

**Method for receiving your health information: (check only one box below)**

☐ Paper

☐ Email (Encrypted) In an effort to protect your health information, our standard practice is to encrypt our email.

☐ Email (Unencrypted) Signature Required. By signing you acknowledge that you understand an unencryped email exposes your personal and health information to additional security risks. Signature_____

If you require your health information in a format other than paper or email, please contact us at the number listed above. We may be able to accommodate your request at an additional charge.

**Records from other Walgreens entities:**

Please contact us if you need to receive records from other Walgreens entities.

# Authorization to Release Protected Health Information

Walmart sam's club

I authorize the release of ☐ Pharmacy ☐ Vision Center/Optical
information from the following facility: (include city and state):

_____

**What is the Purpose of this Request?**
This request allows you to authorize others (e.g., family, friends, third parties) to access your Protected Health Information ("PHI"). You can authorize the release of your PHI maintained by Walmart and Sam's Club Pharmacies or Vision Centers/Optical Centers. This Authorization will only apply to the health care service area indicated above. You must fill out an Authorization for each Pharmacy or Vision Center/Optical location from which you wish to release your PHI.

**Section 1: Patient Information**

| Patient Name (last, first, middle initial): | | | Date of Birth (mm/dd/yyyy): |
|---|---|---|---|
| Address: | | | |
| City: | State: | Zip Code: | Phone Number: |

**Section 2: Recipient of PHI**

| Individual or Entity Receiving Information: | | | |
|---|---|---|---|
| Address: | | | |
| City: | State: | Zip Code: | Phone/Fax Number: |

**Section 3: Information to be Released (Check all that apply)**

I authorize Walmart to release the following Protected Health Information (PHI) (check all that apply):
☐ Medical Expense Summary (list of all prescriptions with expense information)
☐ Designated Record Set (entire medical record maintained by the Pharmacy)
☐ Dispensing Records (entire record maintained by the Vision Center or Optical)
☐ Other (please describe):
***For the following dates of service***:
☐ All dates of service **OR** From _____ to _____
***For the following purposes:***
☐ At the request of the patient
☐ Other (please describe):

**Section 4: Expiration Date of Authorization**

| This authorization will remain in effect<br>☐ Until the following date: _____ | ☐ Until one year from the date of my signature below. |
|---|---|

**Section 5: Understandings**

- I understand that signing this Authorization is voluntary. Walmart will not deny Pharmacy or Vision Center/Optical services to me if I refuse to sign this Authorization.
- I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by federal or state privacy laws.
- I have the right to revoke this Authorization at any time in writing, by completing a "Revocation of Authorization to Release Protected Health Information" form. The revocation will not apply: (i) to PHI Walmart released in reliance on this Authorization, prior to receiving the revocation; or (ii) if this Authorization was obtained as a condition to the patient obtaining insurance coverage.
- I understand that records released pursuant to this Authorization may include HIV/AIDS related information; mental health information; drug/alcohol diagnosis and treatment information; pregnancy and family planning information; sexually transmitted disease information.

**Section 6: Signature and Date**

_____ _____ _____
Name of Patient or Personal Representative (please print) Signature of Patient or Personal Representative Date

If you have signed this form as a legally authorized representative of the patient, please indicate your relationship/authority to act on behalf of the patient (parent, guardian, etc.): _____

**For Store/Club Use Only**

Store/Club Number:_____

Please initial to verify that you (1) confirmed the form was signed and all sections completed and (2) provided a signed copy of the form to the patient/personal representative: _____

*See POM/VCOG 1610 for more information.*

EXPRESS SCRIPTS®

# Authorization to Use and Disclose Health Information

**PLEASE PRINT CLEARLY**

Patient's Name:_____ ID Number_____

Address:_____ SSN:_____
Street

_____ Date of Birth: _____/_____/_____
City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) _____

[ ] Check here if Plan Sponsor is Department of Defense

I authorize Express Scripts, Inc. or one of its subsidiaries or affiliates to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
   [ ] PBM Prescription Claims Information
   [ ] Only Mail Order Pharmacy Records are requested

2. The health information identified above may be used or disclosed for the following purpose(s):

   _____

   _____

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

   Name: _____

   Address:_____

   E-mail Address _____

4. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

7. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed by Express Scripts,

Inc. once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

Express Scripts, Inc.
Claims Dept – Records/HQ21-06
8455 University Place Drive
St. Louis, MO 63121

8. I understand that I have a right to request and receive a copy of Express Scripts' Notice of Privacy Practices at www.express-scripts.com.

9. A photocopy of this authorization is as valid as the original.

10. I understand that this authorization will expire ten (10) years from the date signed below.

**SIGNATURE**

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

If signed by patient's personal representative, please complete the following and attach supporting documentation:

Relationship to patient: _____

Authority to act for the patient: _____

**Prescription Claims Information is readily available for the previous ten years.** Patients wanting prescription claim information sent to the address on file should call the number on the back of the prescription identification card

Members wanting PBM Prescription Claim Information sent to the address on file free of charge should call the number on the back of the prescription identification card. The Express Scripts website also provides all members the ability to access and print PBM Prescription Claim Information for free for the last 24 months of service by logging into www.express-scripts.com.

Please return the completed form to the address below and allow 6-8 weeks for the request to be processed. For those requests for PBM Prescription Claims Information not submitted by a member's legal personal representative, please also submit a check or money order for the non-refundable fee of $90.00.

Express Scripts, Inc.
Claims Dept – Records/HQ21-06
8455 University Place Drive
St. Louis, MO 63121

**CVS Pharmacy DISCLOSURE AUTHORIZATION FORM**
**One CVS Drive, Woonsocket, RI 02895**
**Fax (401) 652-1593**

## PATIENT REQUESTING DISCLOSURE

Name: _____
Address: _____
Address: _____
Date of Birth _____

I hereby authorize CVS Pharmacy to disclose my Patient Prescription Record (PPR), reflecting my prescription history and any other pharmacy services I have received from CVS Pharmacy as set forth below:

1. My Patient Prescription Record (PPR), may be disclosed to the following person(s) categories of person or entities:
   Name: _____
   Address: _____
   Address: _____

2. Purpose of the release of this information

   ☐ At the request of Patient/Patient's personal representative.
   ☐ Other: _____

3. I understand that my PPR may include information related to treatment of mental health condition, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases. I understand that the information, if any, pertaining to any of the conditions described above may be released.

   ☐ I authorize the release of this information.
   ☐ I do not authorize the release of this information.

4. I understand that I may cancel this authorization at any time by writing to CVS Pharmacy Privacy Office, One CVS Drive Woonsocket, RI 02895, or fax to 401-765-9304, except to the extent that CVS Pharmacy has taken action in reliance on this authorization.

5. I understand that signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment from the CVS Pharmacy, any payment for treatment or enrollment or eligibility for benefits. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.

6. I understand that if the person or entity that receives my PPR is not required to comply with the applicable privacy regulations, the information described above may be redisclosed by the recipient and no longer be protected by those regulations.

7. I understand that I have the right to receive a copy of this Authorization.

8. This authorization will expire 6 months from the date I sign it as shown below on this authorization unless I enter a different expiration date here _____.

_____ _____
Signature of Patient or Personal Representative * Date

*If signed by someone other than the patient, please explain your authority to act on behalf of the patient: _____

RITE AID

# Attorney Authorization

I authorize Rite Aid to disclose medical information at my request that it maintains to- Litigation Management, Inc. for use in my legal representation. This Authorization includes any and all information Rite Aid may have about me, including, but not limited to, information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy data and EKG's.

I understand that the potential exists for my information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and to be no longer protected.

This authorization will expire one year from the date of my signature as indicated below.

I understand that Rite Aid may not disclose my information as requested above without my signature on this Authorization and that my signing or refusing to sign this Authorization will not affect my ability to receive treatment, payment or health care operations from Rite Aid.

I understand that I have the right to revoke this authorization in writing at any time prior to the expiration date by sending my written revocation to Privacy Office, Rite Aid Corporation, P. O. Box 3165, Harrisburg, PA 17105. Any actions based on this Authorization that Rite Aid may have taken prior to their receiving notice of my revocation will be considered validly authorized.

Patient _____ Parent or Guardian _____
Power of Attorney _____ Court Appointed _____

Date_____ Signature _____
Printed Name_____
Social Security Number _____
Date of Birth _____

CVS caremark®

**Authorization for a one-time written release of personal health information**

Requesting the records of the following Plan Member:
Last Name: _____
First Name: _____ Middle Initial: _____
Previous Last Name (if applicable): _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Date of Birth: _____ (mm/dd/yyyy) Phone Number: (_____) _____-_____

CVS Caremark® Plan Member's Primary Cardholder Identification Number(s): _____

Name of Requestor (if different than above): _____
Relationship to Plan Member:
[ ] Self [ ] Legal guardian (Attach legal documentation)
[ ] Parent [ ] Other: _____
(Attach legal documentation)

I hereby authorize CVS Caremark to release the following information for the above Plan Member:
[ ] Statement of Cost (financial report) from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
[ ] Detailed Prescription History from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
[ ] Other health information (please specify): _____
from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

I understand that my Personal Health Information may include information related to treatment of mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases. I understand that the information, if any, pertaining to any of the conditions described above may be released.
[ ] I authorize the release of this information.
[ ] I do not authorize the release of this information.

This information should be released to: [ ] Check if same as address above.
Name: _____
Organization/Entity: _____
Address: _____
City/State/ZIP: _____

The purpose of this authorization request is:
[ ] At request of the plan member,
[ ] Required or requested by the recipient for purposes of _____
[ ] Other: _____

***This authorization will expire 90 days from the date of this authorization.***

I understand that I have the right to revoke this authorization at any time. This revocation will not affect any uses and/or disclosures already made based on this authorization before the revocation is received by CVS Caremark. The revocation must be in **writing** and mailed to the address below. I understand that CVS Caremark may not condition any treatment, payment, enrollment or my eligibility for benefits on my signing this authorization. I understand that the information used and/or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the federal privacy law.

I certify that the foregoing information is true and correct.
Signature: _____ Date: _____

Print Name: _____

If signed by someone other than the above-named plan member, please describe your legal authority to act on behalf of the plan member, and, if applicable: _____
(Attach supporting documentation)

Witness Signature: _____

Witness Name: _____ Date: _____

**Please Return Form To:**
CVS Caremark
Attn: Research Department
P.O. Box 6590
Lee's Summit, MO 64064

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.