UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: GADOLINIUM BASED CONTRAST AGENTS PRODUCTS LIABILITY LITIGATION	Case No. 1:08 GD 50000 MDL No. 1909 Honorable Dan Aaron Polster
THIS DOCUMENT APPLIES TO ALL CASES	**CASE MANAGEMENT ORDER NO. 5**

PRODUCT IDENTIFICATION,
PLAINTIFF FACT SHEETS AND DEFENSE FACT SHEETS

I. SCOPE AND INTENT OF ORDER

1. This Order shall apply to all Plaintiffs and their counsel for actions relating to Gadolinium-based contrast agents ("GBCAs") that are currently pending in MDL No. 1909, hereafter subject to transfer to these proceedings, or that have been or will be originally filed in this Court (collectively, "the MDL proceedings") and all Defendants and their counsel in the MDL proceedings.

2. This Order governs the form and schedule for the service of a Plaintiff Fact Sheet ("PFS") and executed Authorizations for the Release of Records to be completed by Plaintiffs. This order also governs the form and schedule for the service of a Defendant Fact Sheet ("DFS") to be completed by each Defendant.

3. This Order neither applies to nor imposes any DFS obligation on any Defendant in any individual action in MDL 1909 other than the sponsors or manufacturers of GBCAs (i.e., the Order does not impose a requirement that a non-

GBCA sponsor/manufacturer like a physician, hospital or distributor like Novation, LLC produce a DFS).

4. The timing and substance of any additional case specific discovery (including depositions) beyond that which is described herein will be the subject of a subsequent CMO.

5. In order to achieve the purposes expressed in paragraphs 2 and 3 above, this Order differentiates between the obligations that will be imposed on the Parties in cases where: (a) Plaintiff has provided good faith substantiation of a specific GBCA manufactured by a particular Defendant; and (b) cases where Plaintiff is unable to provide good faith substantiation regarding the identity of the specific GBCA used for any or all such procedures.

II. PLAINTIFF FACT SHEETS

6. Service of Plaintiff Fact Sheets: Plaintiffs in all cases shall complete and serve upon all Defendants (including sales and distributor Defendants) named in an individual action a PFS and shall produce all responsive non-privileged documents in his or her possession that are called for in the PFS. The PFS form is attached hereto as Exhibit 1. Plaintiffs whose cases are pending in this Court at the time of this Order shall have until July 21, 2008 to produce a completed PFS, signed and dated authorizations, and all requested documents in his or her possession. Plaintiffs must provide a complete and good faith response to all questions in the PFS to the best of his or her ability and may, if necessary, indicate that the question is not applicable to Plaintiff, or, after a good faith investigation, that Plaintiff does not know or cannot recall the answer to a question. Plaintiffs shall make a good faith effort to substantiate his or her allegations identifying

exposure to a particular GBCA product(s) and the respective Defendant(s). For Plaintiffs whose cases are not pending in this Court at the time this Order is entered, the completed PFS, signed and dated authorizations and all other requested documents in his or her possession shall be produced within forty-five (45) days after the date the case is docketed in this MDL Court. Plaintiffs remain under a continuing duty to supplement the PFS, if needed, throughout the litigation.

7. Defendants' Obligation to File Responsive Pleadings: Defendants' are obligated to file a responsive pleading to a complaint no later than thirty (30) days following receipt of a PFS or Supplemental PFS which contains good faith substantiation of Plaintiff's allegations that a specific GBCA manufactured by a particular Defendant or Defendants is identified for each procedure(s**).**

8. Non-Mental Health Medical Authorizations: Each person who produces a PFS according to paragraph 6 of this Order shall also produce an Authorization for Release of Records for each non-mental health medical provider (including insurer and pharmacies) listed in the PFS. The Non-Mental Health Medical Authorization to be used is attached hereto as Exhibit 2 and shall be served on Defendants' Liaison Counsel in accordance with paragraphs 15 and 18 of this Order.

9. Mental Health Authorizations: Each person who produces a PFS according to paragraph 6 of this Order who also alleges a specific psychiatric injury or damage as described in Section II.G. question 3 of the PFS, shall, in addition to the non-mental health medical provider releases described in paragraph 8 above, serve an original signed authorization for the release of records from each mental health care provider identified in the PFS, Section II.G, question 3. The Mental Health Records

Authorizations that Plaintiff must complete in such cases is attached hereto as Exhibit 3 and shall be served on Defendants' Liaison Counsel in accordance with paragraphs 15 and 18 of this Order.

10. Employment Authorizations: Each person who produces a PFS according to paragraph 6 of this Order and who alleges past or future lost earnings as a result of administration of GBCA(s) as described Section II.B. question 16 of the PFS must also serve upon counsel for any Defendant named in his case an original release for employment records for each employer identified in the PFS. Notwithstanding allegations of past or future lost earnings, where health conditions, injuries or work environment factors may relate to Plaintiff's claim(s), Defendant(s) may request an Employment Authorization and the Parties will meet and confer regarding such production. The Employment Authorization is attached hereto as Exhibit 4 and shall be served on Defendants' Liaison Counsel in accordance with paragraphs 15 and 18 of this Order.

11. Supplemental "Blank" Authorizations: In each case where Plaintiff has filed a PFS according to paragraph 6 of this order, Plaintiff's counsel shall obtain and hold in their possession an initial set of twenty-one (21) blank releases which Defendant(s) may request upon discovery of specific medical providers, mental health providers or employers not previously identified by Plaintiffs. These twenty-one (21) blank releases shall consist of fifteen (15) blank Non-Mental Health Authorizations (Exhibit 2), three (3) blank Mental Health Records Authorizations (Exhibit 3); and three (3) blank Employment Authorizations (Exhibit 4). Defendants reserve the right to request additional authorizations as may be necessary.

12. Request for Supplemental Authorizations: Following service of the PFS, Defendant(s) whose products have been specifically identified as having been administered to Plaintiff may request that Plaintiff's counsel produce additional supplemental authorizations(s) that were held pursuant to paragraph 11 above. Any request for additional authorizations must be made in writing and delivered by electronic means and must identify the particular provider or other entity whose records are being sought. Within seven (7) business days of electronic service of the request, Plaintiff's counsel shall either produce a signed authorization or notify Defendant(s) by electronic means that they object to the execution of the signed authorization(s). Plaintiff and Defendant(s) may agree to additional time.

13. "Special" Authorizations: If a health care provider, employer or other custodian of records: (a) requires a specific form of authorization that is different than the authorizations set forth in this Order; (b) requires an authorization executed more recently than the those provided by Plaintiff to Defendant(s); (c) requires a notarized authorization; or (d) requires an original signature, Defendant(s) shall notify Plaintiff's counsel of the requirement(s) by electronic means and Plaintiff shall either produce a signed authorization within seven (7) business days or notify Defendant(s) by electronic means that they object to the execution of a signed authorization.

14. Pathology Collection: The authorizations produced pursuant to this Order shall not cover the release of pathology specimens or tissue and no release obtained pursuant to this Order may be used to obtain or collect original tissue or pathology samples, unless agreed to by Plaintiff and Defendant(s). A pathology protocol shall be covered by an additional Order from the Court.

15. Authorizations in Cases Involving Multiple Defendants: In cases where there are multiple Defendants, Plaintiff shall not be required to provide separate authorizations to each Defendant with the PFS, unless agreed to by Plaintiff and Defendant(s). Rather, in cases involving multiple Defendants, Plaintiff will serve all required authorizations to Defendants' Liaison Counsel who will coordinate distribution and record collection.

16. Access to Medical/Employment Records: Defendant(s) or its/their authorized agents shall make available all records obtained through use of authorizations exchanged pursuant to this Order through an outside vendor(s). The Parties shall meet and confer to resolve appropriate cost-sharing, if any, Bates-stamping, web-site access, viewing fees and copying costs issues, and third-party access issues (e.g., a treating physician Defendant or other third party or, as the case may be, a Plaintiff, who also wishes to obtain the records). Access to the records of any individual Plaintiff will be limited to his or her counsel of record and counsel for the Defendants named in Plaintiff's case. If records collected pursuant to any authorization or are otherwise received by either Party within three (3) days before a scheduled deposition, each Party will notify the other Parties' counsel and produce or make available such records immediately, but not less than twenty-four (24) hours, prior to any deposition (unless the records are received less than twenty-four (24) hours prior to the deposition).

17. Verification: Plaintiff's responses to the PFS shall be signed by the Plaintiff and treated as answers to interrogatories under Fed. R. Civ. P. 33 and responses to requests for production of documents under Fed. R. Civ. P. 34.

18. Service and Confidentiality: Plaintiff shall be obligated to serve his or her executed PFS and related documents (other than authorizations) on counsel for all Defendants named in the individual case. Further, a PFS and related documents (including health care records and information) are confidential and will be treated as "Confidential Documents" pursuant to the terms or the Protective Order (CMO No. 6).

III. THIRD PARTY DISCOVERY WHERE PLAINTIFF IS UNABLE TO SUBSTANTIATE IN GOOD FAITH ALLEGATIONS SUPPORTING PRODUCT IDENTIFICATION.

19. Where Plaintiff Is Not Able to Substantiate in Good Faith Allegations Supporting Product Identification: If Plaintiff is unable to substantiate in good faith his or her allegations identifying the GBCA product(s) administered to Plaintiff, Plaintiff shall be required to conduct third-party discovery in furtherance of efforts to expeditiously ascertain the identity of the manufacturers or sponsors. These efforts shall commence promptly following service of Plaintiff's PFS to Defendant(s) pursuant to Section II.6 of this Order. The method of third-party discovery may be by any means permitted by the Federal Rules of Civil Procedure, including a Subpoena for Documents under Rule 45, a Deposition Upon Oral Questions under Rule 30 (including a telephonic deposition pursuant to Rule 30(b)(4) on consent of the parties or otherwise in accordance with the Federal Rules) or a Deposition Upon Written Questions pursuant to Rule 31. The parties must comply with the notice requirements set forth under Rule 45.

20. Service of Supplemental PFS: If, after receiving Part 1 of the DFS and completing third-party discovery, Plaintiff is able to identify the specific manufacturer(s) or sponsor of any relevant procedure, Plaintiff shall provide a Supplemental PFS incorporating the identity-substantiating information as set forth in paragraphs 15 and 18.

21. Product Identification Notification/Meet and Confer: In the event that Plaintiff is unable to substantiate in good faith product identification after receiving Part 1 of the DFS and completing third-party discovery pursuant to this Order, Plaintiff shall notify the Defendant(s) of such fact ("Product Identification Notification"). All Parties shall meet and confer regarding outstanding product identification issues, including any additional discovery that may be needed, within fifteen (15) days of Defendants' receipt of Product Identification Notification. No communications between counsel for the parties shall be deemed evidence of lack of product identification.

22. Dismissal Where Product Identification Is Not Substantiated: In the event that Plaintiff is unable to substantiate in good faith product identification after receiving Part 1 of the DFS as set forth in Section IV below and completing third-party discovery as set forth in Section III of this Order, the non-identified named Defendants shall be dismissed without prejudice upon Defendant's motion.

IV. DEFENDANT FACT SHEETS

23. Service of Defendant Fact Sheet if Product Identification is Substantiated: Each sponsor or manufacturing Defendant is obligated to complete in good faith and serve upon Plaintiff in an individual case a completed Defendant Fact Sheet, including Part 1 ("Defendant Product Identification") and Part 2 ("Defendant Case Profile"), and all responsive documents called for in the DFS, forty-five (45) days after receipt by that Defendant of a full and complete PFS as required by paragraph 6 above or Supplemental PFS (including all required authorizations and accompanying documents) which contains and includes good faith substantiation of use of that particular Defendant's GBCA product prior to the diagnosis of NSF in the case. Defendants remain under a continuing

duty to supplement the DFS, if needed, throughout the litigation. The DFS form is attached hereto as Exhibit 5.

24. Defendants' Obligations to Serve Part 1 (Product Identification) DFS: If Plaintiff is unable to substantiate in good faith use of that particular Defendant's GBCA in the initial PFS, the named Defendants shall be obligated to serve responses only to Part 1 of the DFS ("Defendant Product Identification") forty-five (45) days after receipt of Plaintiff's PFS. Defendants must provide a complete and good faith response to Part 1 of the DFS and remain under a continuing duty to supplement the DFS, if needed, throughout the litigation.

25. DFS "Part 1" Responses Not Deemed Conclusive of Product Identification: Nothing contained in this Order, nor any answer by any Defendant in Part 1 of the DFS, shall be deemed to relieve any Plaintiff of the burden of substantiating in good faith exposure to a specific GBCA prior to the diagnosis of NSF. Further, no answer by any Defendant in Part 1 of the DFS shall preclude any Defendant from asserting that any Plaintiff has failed to carry his or her burden of proving exposure to a specific GBCA prior to the diagnosis of NSF.

26. Verification: Defendants' responses to the DFS shall be signed and treated as answers to interrogatories under Fed. R. Civ. P. 33 and responses to requests for production of documents under Fed. R. Civ. P. 34.

V. PRODUCT IDENTIFICATION DISCOVERY AND FACT SHEET COMPLIANCE AND MOTION PRACTICE

27. Local Rules and Procedure to Apply. Disputes with respect to all Fact Sheets shall be governed by the Local Rules and customs of practice in the Northern District of Ohio.

28. Fact Sheet Deficiency Dispute Resolution. If any Party disputes the sufficiency of responses in the Fact Sheets, that Party shall notify the Party that served the Fact Sheet, in writing, of the alleged deficiencies. If the Parties are unable to resolve the dispute, either Party may send, by facsimile, a letter to the Court requesting the Court's intervention.

29. Notice of Delinquent Fact Sheets. If a Party believes that a Fact Sheet is past due under this Order, that Party shall send written notice to the Party identifying the case name and docket number, and purported due date(s) of the delinquent Fact Sheet. If the Parties are unable to resolve the dispute, either Party may send, by facsimile, a letter to the Court requesting the Court's intervention.

Cleveland, Ohio, this 16th day of June, 2008

/s/Dan Aaron Polster
DAN AARON POLSTER
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: GADOLINIUM BASED CONTRAST AGENTS PRODUCTS LIABILITY LITIGATION	Case No. 1:08 GD 50000 MDL No. 1909 Honorable Dan Aaron Polster
Plaintiff Name, -against- Defendant Name	Case No.

DEFENDANT FACT SHEET

As set forth in Case Management Order ("CMO") No. 5, where applicable, each named Defendant must complete this Defendant Fact Sheet ("DFS"). This DFS must be completed and served on all counsel in the action identified below in accordance with the procedures set forth in CMO No. 5.

In answering the following questions, the term "Plaintiff" refers to the party who alleges that they were injured, including a decedent who is represented by an administrator. The term "dispensing healthcare provider" refers to the healthcare provider(s) identified by plaintiff in Section I 1(c) and (d) of his or her PFS respectively as: (1) the healthcare provider(s) who prescribed/ordered and performed each MRI, MRA, CT scan, angiogram, venogram or other procedure which plaintiff alleges contained a Defendant's Gadolinium-based Contrast Agent ("GBCA") and (2) the healthcare provider which actually performed the procedure. The term "radiographic facility" refers to the facility identified in Section I 1(e) of the PFS as the place where each such procedure was performed. Defendant may attach documents if necessary to answer completely the following questions.

CASE INFORMATION

This DFS pertains to the following case:
Case Caption:_____
Civil Action No:_____
Court in which action was originally filed:_____
This DFS is provided on behalf of the following defendant(s):_____

PART 1 – DEFENDANT PRODUCT IDENTIFICATION

I. DEFENDANT PRODUCT IDENTIFICATION

A. Sales and Distribution of GBCAs to Plaintiff's Dispensing Healthcare Providers or Radiographic Facilities

For each dispensing healthcare provider(s) or radiographic facility identified in the PFS, please state to the best of your recollection the following information, to the extent it exists, for the period three (3) years prior to the alleged administration of Defendant's GBCA through the date of administration:

1. To the best of your knowledge, did you sell any GBCAs directly to any of Plaintiff's dispensing healthcare provider(s) or radiographic facilities?

   _____ Yes _____ No _____ Do Not Know

2. To the best of your knowledge, did you distribute any GBCAs directly to any of Plaintiff's dispensing healthcare provider(s) or radiographic facilities?

   _____ Yes _____ No _____ Do Not Know

3. If your answer is "yes" to Questions A.1 or A.2 above, please provide the following information for the period three (3) years prior to the alleged administration of Defendant's GBCA through the date of administration:

Name of healthcare provider(s) or radiographic facility	**Dates that you sold or distributed GBCAs to the facility**	**GBCA that you sold or distributed**

4. To the best of your knowledge, did you sell or distribute any GBCAs through an agent, contractor or subcontractor, distributor or sub-distributor to any of Plaintiff's dispensing healthcare provider(s) or radiographic facilities?

5.

   _____ Yes _____ No _____ Do Not Know

6. If your answer is "yes" to Question A.4 above, please provide the following information for the period three (3) years prior to the alleged administration of Defendant's GBCA through the date of administration:

Name of healthcare provider(s) or radiographic facility	**Dates that your agent or distributor sold or distributed GBCAs to the facility**	**Identity of agent or distributor**	**GBCA that you sold or distributed**

PART 2 – DEFENDANT CASE PROFILE

II. CONTACTS AND COMMUNICATIONS WITH DISPENSING HEALTHCARE PROVIDERS

For each dispensing healthcare provider(s) identified in the PFS, please provide the following information, to the extent it exists, for the period three (3) years prior to the alleged administration of Defendant's GBCA through the date of the initial filing of the complaint in Plaintiff's lawsuit:

A. Dear Doctor or Dear Healthcare Provider Letters

1. Have you sent any of Plaintiff's dispensing healthcare provider(s) or radiographic facilities a "Dear Doctor" or "Dear Healthcare Provider" letter or documents containing such responsive information concerning NSF/NFD and the GBCA(s) allegedly administered to Plaintiff?

_____ Yes _____ No

2. If your answer is "yes," please provide the following information for each letter sent:

In lieu of answering the below questions in A.2, Defendant may attach documents that are the subject of these requests.

Identity of letter	**Date(s) each letter was sent to the dispensing healthcare provider(s) or radiographic facility**	**Name of the person(s) to whom each letter was sent**	**Address where letter was sent**

3. If your answer is "yes," but you are unable to provide the information requested in question II.A.2 or attach documents that are the subject of these requests, please provide an explanation for your inability to provide the information or attached the documents.

_____

B. <u>Consulting with Plaintiff's Dispensing Health Care Provider(s)</u>

To the best of your knowledge, have you retained any of Plaintiff's dispensing healthcare provider(s) as a thought leader, a member of a "speakers bureau," a member of an Advisory Panel, clinical trial investigator, or a consultant in any other capacity on the subject of marketed GBCA(s)?

_____ Yes _____ No

If your answer is "yes," please provide the following responsive information.

In lieu of answering the below questions in B, Defendant may attach documents that are the subject of these requests.

Identity of Plaintiff's dispensing healthcare provider	**Date(s) he or she was retained**	**Amounts of money you paid in expenses, honoraria and/or fees**

C. <u>Communications with Plaintiff's Dispensing Healthcare Providers Regarding GBCA(s), NSF or NFD (not to include sales and marketing departmental files or any other custodial files)</u>

1. To the best of your knowledge, have any of Plaintiff's dispensing healthcare providers identified in the PFS contacted you to request information concerning GBCA(s), NSF or NFD for the period three (3) years prior to the alleged administration of Defendant's GBCA through the date of the initial filing of the complaint in Plaintiff's lawsuit?

*Note: This request relates to information from the relevant and responsive departmental files, and does not call for information from any sales and marketing departmental or custodial files, or from any other

individual custodial files, which information may be covered by a future CMO.

_____ _____
Yes No

2. If your answer is "yes," please identify and attach all documents, database reports and information from databases which are responsive to the information requested above.

D. <u>Sales Representative Call Note Database Information</u>

1. Have any of your sales representatives contacted Plaintiff's dispensing healthcare providers for the purposes of detailing or marketing your marketed GBCA(s)?

_____ _____
Yes No

2. If your answer to question D.1 is yes, to the extent such information is collected and maintained in the ordinary course of Defendant's business in database form, please produce a report of the information contained in that database that identifies all contacts between any sales representatives or detail persons and Plaintiff's dispensing health care provider, during the time period of three (3) years before Plaintiff allegedly was administered Defendant's GBCA until the date of the initial filing of the complaint in Plaintiff's lawsuit.

- The reports produced should include, but not be limited to, all fields, if applicable, that would provide responses to the following requests:

  (a) Name of Plaintiff's dispensing healthcare provider;

  (b) Name of the sales representative or detail person who contacted Plaintiff's dispensing healthcare provider;

  (c) All fields relating to the nature and substance of such contact or communication; and

  (d) Date of contact or communication.

- This question does not require Defendant to collect and create a database where one does not already exist, or create a document that contains this information if such information is not kept in database form in the ordinary course of business by that Defendant.

- All information produced in response to this Section shall be produced pursuant to the terms of any Protective Order, Format of Production Order, or any other order governing production of documents in this litigation.

3. For all sales representatives or detail persons listed in the above report who are no longer employed by the Defendant, please provide:

Name of the former sales representative or detail person:	**Last known address and telephone number of the former sales representative or detail person:**

III. CONTACTS REGARDING PLAINTIFF

A. Have you been contacted by Plaintiff or anyone on behalf of Plaintiff concerning Plaintiff's alleged injury (other than contacts between counsel for the parties during the course of the litigation)?

_____ _____
Yes No

B. If your answer is "yes," please identify the person(s) who contacted you and the person(s) who were contacted.

_____

C. Do you have in your possession any Medwatch Report(s) related to Plaintiff?

_____ _____
Yes No

1. If your answer is "yes," please attach hereto a copy of the Medwatch Report(s), and if available, any supporting source documents.

2. Did you or any consultant, in the normal course of business, perform an analysis or review of medical or scientific information concerning the Plaintiff who is the subject of this case? (Note: This question does not require Defendant to reveal or produce information protected by privilege, including, but not limited to, work product of attorneys or retained consulting experts.)

Yes____ No____ Do not know _____

3. If your answer to question C.3 is "yes," please identify the person(s) performing the analysis or review, their current address, and produce all documents relating to the analyses performed concerning the Plaintiff. (Note: This request does not require Defendant to reveal or produce information or documents protected by privilege, including, but not limited to, work product of attorneys or retained consulting experts.)

IV. DOCUMENT REQUESTS

1. Any and all documents or reports from electronic databases in your possession that are responsive to a request contained within this DFS, but which do not expand any obligations for production contained in the requests above.

2. All contracts or agreements between Defendant and Plaintiff's specific dispensing healthcare provider(s) or radiographic facilities regarding the sale of GBCA(s) for the period three (3) years prior to the alleged administration of Defendant's GBCA through the date of administration.

VERIFICATION

I, _____, make this Verification on behalf of Defendant(s) _____, being authorized to do so. I declare under penalty of perjury that all of the information provided in this Defendant Fact Sheet is true and correct to the best of my knowledge. I have supplied all the documents requested in Section IV of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of the Defendant or its lawyers.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respects incomplete or incorrect.

_____ _____

Date Signature of Defendant Representative

_____

Position of Defendant Representative

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO

----------X

IN RE GADOLINIUM CONTRAST AGENTS

PRODUCTS LIABILITY LITIGATION
----------X
THIS RELATES TO MDL DOCKET NO. 1909
PLAINTIFF: _____
(name(s))

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who was exposed to gadolinium-based contrast agent(s) ("GBCA"). Whether you are completing this fact sheet for yourself or for someone else, please assume that "You" means the person who was exposed to gadolinium-based contrast agent(s). In filling out this form, please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, Radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you. **Please attach additional sheets as necessary and indicate the questions to which the answers pertain.**

SECTION I—CASE INFORMATION AND PRODUCT IDENTIFICATION

1. Name of person completing this form: _____

2. Name of person on whose behalf a claim is being made: _____

3. Please state the following for the civil action that you filed:

   a. Case caption:_____

   b. Docket Number: _____

   c. Court in which action was originally filed:_____

   d. Name, address, telephone number, fax number and email address of principal attorney representing you:

      Name: _____

      Firm: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

4. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

   a. Your name, including other names you have used or by which you have been known and dates you used those names: _____

   _____

   b. Current Address: _____

   c. Describe the capacity in which you are representing the individual or estate:

   _____

   d. If you were appointed as a representative by a court, state the:

      Court which appointed you: _____

      Date of Appointment: _____

   e. What is your relationship to the individual you represent: _____

   f. If you represent a decedent's estate, state:

      Date of Death: _____

THE REMAINDER OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS EXPOSED TO A GADOLINIUM-BASED CONTRAST AGENT

A. Product Identification (Radiological History, Contrast Use /Exposure/GBCA Administration)

1. Have you ever had a medical procedure using magnetic resonance imaging (MRI) or magnetic resonance angiography (MRA), CT scan, angiogram, venogram or other procedure in which you were exposed to a gadolinium-based contrast agent?

   Yes ____ No _____

2. For each procedure you are currently aware of, please provide the following information. Use additional pages to continue your answer if necessary:

(NOTE: In lieu of responding to this question, you may attach a copy of any MRI, MRA, CT scan, angiogram, venogram or other procedure report that you have in your possession that provides the requested information.)

a. Date of the procedure: _____

b. Type of procedure:_____

c. Name of the healthcare provider who prescribed/ ordered each procedure:

_____

d. Name of the healthcare provider who performed each procedure:

_____

e. Name and address of the facility where each procedure was performed:

_____

f. Reason for each procedure:

_____

g. For each procedure, please indicate which gadolinium based contrast agent you have been exposed to, and dates when exposed:

Magnevist	_____	Dates_____
MultiHance	_____	Dates_____
Omniscan	_____	Dates_____
Optimark	_____	Dates_____
ProHance	_____	Dates_____
Other (provide name)	_____	Dates_____
Unknown	_____	Dates_____

3. Do you or your attorney have any documents that identify the trade name, specific chemical name, or manufacturer/sponsor of the contrast agent used in each procedure? (If you have documents please produce copies.)

   Yes _____ No _____

4. Do you have any other information indicating the specific contrast agent used for each procedure? If so, please explain:

   _____

5. For each procedure identified in response to question A(2) above, do you recall receiving any written or oral instructions, materials or warnings about the contrast agent at the time of any each procedure?

Yes ____ No _____ Do not recall_____

If yes, describe the materials you received, identify who provided them, and state whether you or your attorneys still have the materials. (If you have the materials please produce a copy.):

_____

6. Do you recall discussing the use of a contrast agent with any healthcare provider at the time of any of each procedure?

Yes _____ No _____ If yes, describe the information you received

_____

SECTION II—MEDICAL AND OTHER INFORMATION

A. NSF Diagnostic Information

1. Are you claiming that exposure to GBCA caused you to have Nephrogenic Systemic Fibrosis ("NSF") or Nephrogenic Fibrosing Dermopathy ("NFD")?

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

a. Have you been diagnosed with NSF/NFD? Yes ____ No ____

b. Provide the name and address of every doctor or other healthcare provider who has diagnosed or told you that you have nephrogenic systemic fibrosis (NSF), nephrogenic fibrosing dermopathy (NFD), or any medical conditions that you claim are or may be caused by exposure to GBCAs or any contrast agents, and provide the information in the chart below.

Diagnosing Healthcare Provider	Date of Diagnosis, if any	Diagnosis, if any, and symptoms

2. Has any health care provider ever performed a skin tissue or biopsy on you for the purpose of diagnosing NSF or NFD?

   Yes _____ No _____ Cannot Recall _____

   If yes, please answer the following questions.

   (NOTE: In lieu of responding to the (a), (b), (c) and (d) below, you may attach the biopsy report in question that provides the requested information.)

   a. Name and address of the health care provider who performed the biopsy:

   _____

   b. Name and address of the health care provider who ordered the biopsy:

   _____

   c. Reason for biopsy:

   _____

   d. Date of biopsy:

   _____

3. Was NSF/NFD confirmed by any healthcare provider following a biopsy?

   Yes _____ No _____

4. What treatment have you undergone, or are you undergoing, for your NSF/NFD?_____

5. If a biopsy was not performed in connection with your diagnosis of NSF/NFD or other injuries that you allege are related to gadolinium based contrast agents, explain why you did not have the biopsy, to the extent that information is known by you.

   _____

   _____

6. Have you or any of your health care providers reported the occurrence, if you know, of the injuries you are claiming to any NSF registry, including the Registry operated by Dr. Shawn Cowper at Yale University, or the FDA MedWatch system?

   Yes _____ No _____ Unknown _____

If yes, provide the date of the report, the method of communication, the names of all person(s) who made the report, and the substance of the report (If the report was in writing, and you have a copy in your possession, please produce a copy.):

_____

_____

7. Have you had any communications with healthcare providers, orally or in writing, about whether your condition is related to your exposure to gadolinium-based contrast agents?

Yes_____ No_____ Cannot recall_____

If yes, please identify the name, address and approximate date of communication with said healthcare provider:

_____

_____

If yes, please describe the conversations in detail:

_____

B. PERSONAL INFORMATION

1. Name: _____
2. Maiden or other names used and dates you used those names:

_____

3. Current Address and Date when you began living at this address: _____
4. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____

6. Date and Place of Birth: _____

7. Current Marital Status: _____

8. Spouse's name and date of marriage: _____

9. If married, has your spouse filed a loss of consortium or other claim in connection with this lawsuit?

   Yes_____ No_____

10. If your Spouse is asserting a loss of consortium claim, state his or her occupation:

    _____

11. If you have children, please identify each child's name and address and date of birth.

Child's name and address	Date of birth

12. Please list the name and address of your spouse, parents and siblings:

Name	Address	Relationship

13. Identify all schools you attended, starting with high school:

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

14. Are you currently employed? Yes _____ No _____

If yes, please identify your current employer with name, address and telephone number and your position there: _____

_____

If not, did you leave your last job for a medical reason? Yes _____ No _____

If yes, describe why you left:

_____

15. Identify all of your employers for the last ten (10) years and provide the following information:

Name of Employer	Dates of Employment	Occupation

16. Are you making a claim for lost wages or lost earning capacity?

Yes _____ No _____

17. Have you ever served in any branch of the military?

Yes _____ No _____

Branch and dates of service: _____

If yes, were you ever discharged for any reason relating to your medical or physical condition? _____

18. Identify each insurance carrier with whom you had health insurance coverage at any time in the past ten (10) years:

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

19. Have you ever received Medicare, Medicaid or other government medical benefits within the past ten (10) years?

Yes _____ No _____

If yes, please describe the benefits received:_____

20. Have you applied for workers' compensation, social security, and/or state or federal disability benefits within the past ten (10) years?

Yes _____ No _____

If yes, then as to each application, separately state:

a. Date (or year) of application:
_____

b. Nature of claimed injury/disability:
_____

c. List the agencies to which you submitted your application: _____
_____

21. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

Yes _____ No _____ If yes, please state the following:

Party You Sued/ Made Claim Against	Court in Which Suit Filed/ Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

22. Have you ever been convicted of, or pled guilty to, a felony and/or a crime of fraud or dishonesty?

    Yes _____ No _____

    If yes, please state the charge to which you plead guilty or which you were convicted of, as well as the court where the action was pending:

    _____

    _____

23. Have you ever used the internet to search, read or engage in discussions, in chatrooms, weblogs (blogs) or message boards containing information relating to the claims made in this lawsuit, including but not limited to NSF and contrast agents:

    Yes _____No _____ Cannot recall_____

    If yes, list the websites, chatrooms, weblogs (blogs), and/or message boards:_____

24. Do you belong to any NSF or NFD support groups?

    Yes _____ No _____

C. HEALTHCARE PROVIDERS

1. Identify each doctor or other healthcare provider (other than psychiatrists, psychologists, social workers or counselors, unless you have made claims relating to psychological or mental injuries) who you have seen for medical care and treatment in the past ten (10) years:

   NOTE: You may exclude incidental providers, like hospital consultants, anesthesiologists and nurses. You may also exclude from this list, providers who saw or treated you for minor injuries and conditions.

Name and Specialty	Address and Telephone Number	Approx Dates/Years of Visits

2. Identify each hospital, clinic, or healthcare facility where you have been hospitalized (in-patient, out-patient, or emergency room visit) in the past ten (10) years inclusive of all surgeries and transplants, and including but not limited to, hospitalizations related to NSF/NFD.

Name	Address and Telephone Number	Admission Date(s)	Reason for Admission

Name	Address and Telephone Number	Admission Date(s)	Reason for Admission

3. Have you ever been on dialysis? Yes ___ No ___

If yes, provide the date you began dialysis (and end date, if applicable), the type and approximate dates of dialysis (hemodialysis or peritoneal dialysis), date(s) and list the locations where you regularly received dialysis (name, address and telephone number).

Name of Dialysis Facility	Address and Telephone Number	Approximate Dates	Type

4. Identify each pharmacy that you recall, has dispensed prescription medication to you in the past ten (10) years:

Name of Pharmacy	Address and Telephone Number of Pharmacy	Approx Dates/Years You Used Pharmacy

D. MEDICAL BACKGROUND

1. Dietary History

   To the best of your recollection, has any health care provider instructed you to restrict or in any way monitor your fluid intake related to dialysis and/or renal function?

   Yes _____No _____

   If yes, list the healthcare provider(s) who instructed you, a general description of the instructions and the approximate date(s): _____

   _____

2. Smoking History

   a. Have you ever smoked cigarettes regularly over a period exceeding one (1) year?

      Yes _____No _____

   b. If you currently smoke cigarettes, what is the average number of packs of cigarettes that you have smoked per day over the past two years?_____

   c. If you have regularly smoked cigarettes in the past but do not smoke now, when did you stop?

      _____

3. Allergies and Allergic Reactions

Are you allergic to any food or medication?

Yes ____ No _____ Unknown_____ If yes, please state the following:

Medication or Food	When Allergy Diagnosed, If Known	Signs or Symptoms of Allergy	Health Care Provider Who Diagnosed Allergy, If Any

4. Other Conditions

   a. To the best of your knowledge, do you recall having been **diagnosed** with any of the following conditions ever? Please select Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart:

Condition Experienced or Diagnosed	Yes	No	Unknown
1. Heart attacks			
2. Angina			
3. Congestive Heart Failure (CHF)			
4. Arrhythmias			
5. Stroke			
6. Transient Ischemic Attack (TIA)			
7. Any diagnosed skin condition (excluding conditions like poison ivy and acne)			
8. Arthritis (either osteoarthritis or rheumatoid arthritis or any rheumatologic condition)			
9. Scleromyxedema			
10. Lupus			

Condition Experienced or Diagnosed	Yes	No	Unknown
11. Amyloidosis			
12. Chronic venous stasis			
13. Raynaud's syndrome			
14. Scleroderma			
15. Sjogren's syndrome			
16. Cancer			
17. Dupuytren's contracture			
18. Diabetes, hypo or hyperthyroidism			
19. Fibromyalgia			
20. Hepatorenal syndrome			
21. Hypertension (for greater than 6 months)			
22. High cholesterol (for greater than 6 months)			
23. Infectious diseases (including tuberculosis, pneumonia, rheumatic fever, typhoid fever, encephalitis, poliomyelitis, malaria)			
24. HIV/AIDS			
25. Kidney disease, including acute or chronic renal failure, end-stage renal disease, cysts, pruritus of renal disease/neuropathy)			
26. Cirrhosis of the liver or hepatitis			
27. Chronic obstructive pulmonary disease or emphysema			
28. Multiple sclerosis			

Condition Experienced or Diagnosed	Yes	No	Unknown
29. Amyotrophic Lateral Sclerosis (ALS)			
30. Parkinson's disease			
31. Alzheimer's disease			
32. Any condition causing paralysis or impaired mobility			
33. Sleep Apnea			
34. Deep vein thrombosis			
35. Bleeding or clotting disorders			
36. Pulmonary embolism			

b. For each condition for which you answered yes in the previous chart, please provide the information requested below:

Condition You Experienced, including its severity	Approximate Date of Onset	Name, Address and Telephone Number of Main Treating Physician(s) or Practice Group(s) (if any)

5. Surgeries/Procedures

For each surgery (invasive or non-invasive) that you have undergone in the past ten (10) years, please provide the information requested below:

[NOTE: You may exclude minor surgical procedures such as dental surgery, stitches and similar procedures.]

Date	Procedure	Facility	Physician Ordering	Physician Administering	Purpose

6. Do you recall having an MRI, MRA or CT scan, or any other radiographic procedure where you were exposed to non-gadolinium based contrast agents, such as iodinated contrast agents?

Yes _____ No_____ Unknown _____

If yes, please list the name of the agent(s), if known (or attach applicable records):
_____

If yes, please list the names of any medical facility where each procedure was performed:_____

E. MEDICATIONS

1. List all of the medications you currently take on a regular basis.

Medication	Dose/ Frequency	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, do you currently take or have you ever taken in the past ten (10) years, any of the following medications, pharmaceutical products, or supplements for more than six (6) consecutive months:

Name of Medication	Yes	No	Do Not Recall
1. Epogen/ EPO/ Procrit			
2. Iron or Iron Supplements			
3. Vitamins			
4. Heart medications (excluding aspirin)			
5. Antibiotics			
6. Anti-inflammatories			
7. Prescription pain medications			
8. Immunosuppressant medications (including glucorticoids, chemotherapy agents, antibodies, tacrolimus, sirolimus and interferons)			
9. Anti-rejection medications			
10. Blood pressure medications			

Name of Medication	Yes	No	Do Not Recall
11. Blood thinners			
12. Chemotherapy			
13. Cholesterol medications			
14. Diabetic medications			
15. Hormone replacement therapy			
16. Steroids (including methylprednisolone)			

3. If you indicated yes to any of the above medications/drugs please provide the following information:

Name of Medication/Drug Used	Dates of Use (Approx.)	Who prescribed medication (i.e. doctor's name or clinic/hospital name)	Purpose

F. FAMILY MEDICAL HISTORY

Please indicate, to the best of your knowledge, whether your parents, siblings, children or grandparents have ever experienced or been diagnosed with any of the conditions listed above in Section II (D)(4). For any such conditions, please indicate which one(s) and provide the following information:

Condition	Date of Onset (Approx.)	Relationship to You	Treatment	Outcome

G. INJURIES & DAMAGES

1. Are you claiming any injury as a result of exposure to gadolinium-based contrast agents?

   Yes _____ No _____

   If yes, please describe in detail your physical injury(ies) you claim were caused as result of your exposure to gadolinium-based contrast agents:

   _____
   _____

2. Have you ever been placed on a transplant list?

   Yes _____ No _____

   If yes, for which organ were you placed on the transplant list:

   _____

   If you are on, or were placed on, a kidney transplant list, please provide the following information:

   a. When were you placed on a kidney transplant list?

   _____

   b. If you were on a transplant list, but subsequently taken off the list, please provide the following information:

      i. When were you taken off the kidney transplant list? _____

_____

ii. Why were you taken off the kidney transplant list?

_____

iii. Identify the individuals, including but not limited to healthcare providers, who have knowledge of these circumstances

_____
_____

3. Do you claim mental and/or emotional damages as a result of your exposure to gadolinium-based contrast agents, or that gadolinium-based contrast agents caused or aggravated any diagnosed psychiatric and/or psychological condition(s)?

Yes _____ No _____

If yes, what mental and/or emotional damages do you claim resulted from, or were aggravated by, your use of gadolinium-based contrast agents:

_____

If yes, and if the emotional damage is more than pain, suffering, mental anguish and the ability to enjoy life, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s) since the age of 18 (or, if under 18, since birth):

Mental/Emotional or Psychiatric/Psychological Diagnosed Condition	Name and address of mental healthcare provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

H. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. Are you filling this out on behalf of an individual who is deceased?

Yes _____ No _____

If yes, please state the following from the Death Certificate of the individual:

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: _____
Place of death (city, state and county): _____
Facility or location where death occurred: _____
Name of physician who signed death certificate: _____
Cause of death: _____

2. Are you filling this out on behalf of an individual who is deceased and on whom an autopsy was performed?

   Yes _____ No _____ If yes, please fill in the information below pertaining to the autopsy and the autopsy report:

   (NOTE: In lieu of the following, please attach a copy of the autopsy report.)

   Date: _____
   Performed by: _____
   Facility where autopsy performed: _____
   Place where autopsy performed (city, state, county): _____
   Describe any and all tissue preserved: _____

SECTION III—DOCUMENT DEMANDS

1. Authorizations: please sign authorizations that are attached hereto as Exhibit A, consistent with CMO 5, for each of the healthcare providers and employers you identified above.

2. Documents in your possession, including writings on paper or in electronic form: If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.

   [NOTE: This request does not require you to produce documents provided to you by your attorneys.]

   a. Any and all of your medical records, medical billing records or insurance records in your possession, custody or control.

   b. A copy of all medical records and/or documents relating to the exposure to gadolinium-based contrast agents at any time in your life.

   c. Any and all medical records which reflect or are related to a diagnosis of NSF/NFD or any allegedly related conditions.

   d. All documents in your possession, custody or control, concerning or relating to any gadolinium-based contrast agent, including those you were and were not exposed to, and including but not limited to communications or correspondence with any manufacturer or sponsor of a gadolinium-based contrast agent, the

government, health care providers, or other patients, plaintiffs or family members of those with NSF/NDF; and copies of all documents you (and not your lawyer) obtained from any source regarding gadolinium-based contrast agents.

e. All documents in your possession, custody or control, concerning or relating to NSF/NFD.

f. If you claim you have suffered a loss of earnings or earnings capacity, your federal tax returns for each of the last five (5) years or W-2s or other tax documents, such as 1099s, for each of the last five (5) years.

g. Documents relating to any claim for damages, including, but not limited to, medical, hospital, pharmacy or other bills.

h. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).

i. Decedent's death certificate and autopsy report (if applicable).

VERIFICATION

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. I have supplied all the documents requested in part IX of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respects incomplete or incorrect.

Date:_____ _____

Signature

AUTHORIZATIONS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:	Social Security Number:
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. 164.508, I understand that:

1. This authorization may include disclosure of information relating to **alcohol and drug abuse, mental health treatment**, except psychotherapy notes, and **confidential HIV related information,** only if I place my initials on the appropriate line in Item 11(a). In the event the health information described below include any of these types of information, and I initial the line on the box in Item 11(a), I specifically authorize release of such information to the person(s) indicated in Item 10.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have a right to request a list of people who may receive or use my HIV-related information without authorization.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. **Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.**

5. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law, except as noted in Item 2.

6. This authorization does not authorize you to discuss my health information or medical care with anyone other than the attorney or governmental agency specified in Item 11(b).

7. This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first; unless it is revoked as provided in Item 3, and shall remain in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof. **The records requester has agreed to pay reasonable charges made by the Provider to supply copies of such records.**

8. This authorization specifically does **NOT** authorize the release of original documents and materials, including tissue slides, tissue blocks and tissue samples.

9. Name and address of health provider or entity to release this information:	
10. Name and address of entity(ies) to whom this information will be mailed or sent:	Name and address of entity as designee to whom this information will be mailed or sent:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

11(a). Specific information to be released:

☑ Medical Records from (insert date) _____ to (insert date) _____**.**

☑ Entire Medical Record, including, but not limited to, patient histories, office notes (except psychotherapy notes, biopsy/pathology specimens and/or materials, and autopsy materials), diagnoses, analyses, progress reports, laboratory reports, test results, x-rays, radiology reports, radiology films or scans (in any form), referrals, consults, billing records, correspondence, prescription records, autopsy reports, pathology reports, death certificates, consents for treatment, insurance records, and records sent to you by other health care providers.

❑ Other: _____ Include: (*Indicate by initialing)*

_____ _____**Alcohol/Drug Treatment**

_____**Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

11(b) ☐ By initialing here _____ I authorize _____

Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

*****This authorization does not authorize you to discuss my health information or medical care with anyone other than the attorney or governmental agency specified in Item 11(b).**

12. Reason for release of information:	13. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **Litigation**	**December 31, 2010 or at the conclusion of the case, whichever occurs first.**
14. If not the patient, name of person signing form:	15. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or authorized representative

ACKNOWLEDGMENT

The undersigned, as the record requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. Section 1746, that the attorney to the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, and the attorney has been given five (5) days advance notice and has been afforded an opportunity to object to the request and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

_____

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL AND/OR PSYCHIATRIC HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:	Social Security Number:
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. 164.508, I understand that:

1. This authorization includes disclosure of all mental health or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified in Item 9, below, disclose full and complete protected medical information spanning the time period of the beginning of my treatment to the present, including the following:

   All mental health, psychiatric, and psychological records, notes, and evaluations, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, marriage or family counseling records, records received by other physicians, pharmacy and prescription record, billing records and records of billing to third party payers and payment or denial of benefits.

2. This authorization includes information relating to **alcohol and drug abuse** and **confidential HIV related information,** only if I place my initials on the appropriate line in Item 11(a). In the event the health information described below include any of these types of information, and I initial the line on the box in Item 11(a), I specifically authorize release of such information to the person(s) indicated in Item 10. If I am authorizing the release of HIV-related, alcohol or drug treatment, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have a right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed in Item 9, below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I also understand and intend this authorization to 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 party indicated below in 11(b).
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. **Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.**
6. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law, except as noted in Item 2.
7. This authorization does not authorize you to discuss my health information or medical care with anyone other than the attorney or governmental agency specified in Item 11(b).
8. This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first; unless it is revoked as provided in Item 3, and shall remain in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof. **The records requester has agreed to pay reasonable charges made by the Provider to supply copies of such records.**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

9. Name and address of health provider or entity to release this information:

10. Name and address of entity(ies) to whom this information will be mailed or sent:

Name and address of entity as designee to whom this information will be mailed or sent:

11(a). Specific information to be released:

☑ Medical Records from (insert date) _____ to (insert date) _____.

☑ Entire Medical Record, including, but not limited to, all mental health, psychiatric, and psychological records, notes, and evaluations, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, marriage or family counseling records, records received by other physicians, pharmacy and prescription record, billing records and records of billing to third party payers and payment or denial of benefits.

❑ Other: _____
_____

Include: (*Indicate by initialing)*
_____ **Alcohol/Drug Treatment**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

11(b) ☐ By initialing here _____ I authorize _____
Name of individual health care provider
to discuss my mental heath information with my attorney, or a governmental agency listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

*****This authorization does not authorize you to discuss my health information or medical care with anyone other than the attorney or governmental agency specified in Item 11(b).**

12. Reason for release of information:
☐ At request of individual
☑ Other: **Litigation**

13. Date or event on which this authorization will expire:

December 31, 2010 or at the conclusion of the case, whichever occurs first.

14. If not the patient, name of person signing form:

15. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or authorized representative

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

ACKNOWLEDGMENT

The undersigned, as the record requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. Section 1746, that the attorney to the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, and the attorney has been given five (5) days advance notice and has been afforded an opportunity to object to the request and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

_____

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 all 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 I 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 if the following are initialed:

_____ **HIV/AIDS information**

_____ **ALCOHOL/SUBSTANCE ABUSE information**

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.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records. I acknowledge that this authorization may include disclosure of confidential information relating to HIV/AIDS testing or treatment and ALCOHOL/SUBSTANCE ABUSE testing or treatment.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508. If HIV/AIDS-related or ALCOHOL/SUBSTANCE ABUSE-related information is released, the recipient is prohibited from redisclosing such information without authorization unless permitted to do so under federal or state law.

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 December 31, 2010 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)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Employee is physically unable to provide a signature. I personally witnessed that the Employee understood the nature of this authorization and freely gave her verbal consent to release her medical records.

_____ _____