UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE SUBOXONE (BUPRENORPHINE/NALOXONE) FILM PRODUCTS LIABILITY LITIGATION	)	Case No. 1:24-md-3092
	)	MDL No. 3092
	)	Judge J. Philip Calabrese
This Document Applies to All Cases	)	

ORDER ADOPTING REVISED FORM AUTHORIZATION

At the request of the parties, the Court approves and adopts the authorization form attached as Exhibit 1. Moving forward, Exhibit 1 substitutes for the authorization forms attached to Case Management Order No. 12 (Census Protocol, ECF No. 158-2) (for purposes of Census and Record Collection Pool (ECF No. 207, PageID #5678)) and Case Management Order No. 13 (Medical Records Order, ECF No. 194-1).

The parties agree that if a Plaintiff has executed a prior approved form of the authorization, Defendants will use that authorization form to seek that Plaintiff's records from providers. If a provider rejects the prior executed authorization form, Defendants may seek execution of the new form.

Nothing in this Order adopting a revised authorization form excuses a provider's failure to comply with a request for records under Case Management Order No. 13 unless the provider's rejection relates to an amended component of the form.

SO ORDERED.

Dated: September 9, 2025

J. Philip Calabrese
United States District Judge
Northern District of Ohio

AUTHORIZATION FOR DISCLOSURE OF MEDICAL/DENTAL INFORMATION

SECTION I. PATIENT DATA

1. **NAME** (*last, first, middle initial*): _____
2. **ALIAS/MAIDEN NAME:** _____
3. **DATE OF BIRTH:** _____
4. **SOCIAL SECURITY NUMBER:** _____
5. **ADDRESS:** _____

SECTION II. FACILITY INFORMATION

1. **NAME/ADDRESS:** _____
2. **DATE BEGIN (5 years prior to initial Suboxone prescription date):** _____
3. **DATE END:** _____
4. **INFORMATION TO BE DISCLOSED:**

[X] Dental and Medical Records (including all dental and medical records, physician's records, notes, reports and orders, hospital records, admission records, emergency room records, surgeon's records, pathology/cytology reports, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, SUD patient records and notes including counseling notes, patient intake forms, consultations, disability records, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence (inclusive of any and all electronic communications (i.e. text messages or electronic mail), patient intake forms and health history forms, telephone logs, telephone messages, prescription records, medication records, orders for medications, social worker's records, insurance records, any medical consent(s), statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records. Copies of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, radiation therapy reports, including, but not limited to dental x-rays, panorexes, or other dental or digital imaging.

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipients or any of their representatives: Bowman and Brooke LLP and/or its agent _____.

The purpose of this authorization is: at my request.

I understand that I have a right to receive a copy of the authorization upon my request pursuant to 45 CFR 164.508(6)(c)(4).

I understand that the information in the patient's health records authorized above 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, or treatment for alcohol or drug abuse.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

This authorization shall remain in full force and effect until it expires three years from the date set forth below.

PHOTOCOPIES OF THIS RELEASE ARE VALID.

ELECTRONICALLY SIGNED COPIES OF THIS RELEASE ARE VALID.

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 by sending or presenting my written revocation to the Privacy Contact of the healthcare provider named above. I understand that the revocation of this authorization will not apply to the extent that the healthcare provider has taken action in reliance thereon.

I understand that authorizing the disclosure of this healthcare information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR § 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

42 CFR part 2 prohibits unauthorized use or disclosure of these records.

Signature: _____ **Date:** _____

(*Patient and/or Legal Representative)*