**LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)**

**TO:**

**Patient Name: SSN: DOB:**

!, , hereby authorize you to release and furnish to: Reed Smith LLP and/or Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights OH 44124, copies of the following information:

* All records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, x-rays, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records created or received by you orother physicians or staff, as well as all autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterizationreports.

All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology /autopsy/immunohistochemistiy specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

**\*\*Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501.**

I. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. This document does not authorize you to discuss with any individual any aspect of the above­ named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. This document does not limit your ability to testify at deposition or trial about any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or** in **the medical records,** or **any other matter bearing on his or her medical or physical condition.**

1. 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).
2. I understand that I have the right to revoke this authorization at any time. I understand that ifl revoke this authorization I must do so in writing and present my written revocation to the health infonnation 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 two years from the date of execution.
3. 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 infonnation may not be protected by federal confidentiality rules. If! have questions about disclosure ofmy health infonnation, I can contact the releaser indicate above.
4. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place ofan original.

Print Name: Signature:

(plaintiff/representative)

Date:--------------

**LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

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* All records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, x-rays, test results, statements, questionnaires/histories,office and doctor's handwritten notes, and records created or received by youor other physicians or staff, as well as all autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterizationreports.

All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistryspecimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

* All pharmacy/prescription records including NDC numbers and drug infonnation handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

**\*\*Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defmed by HIPAA, *45* CFR §164.501.**

1. To my medical provider: **this authorization** is **being forwarded by, or on behalf of, attorneys for the defendants. This document does not authorize you to discuss with any individual any aspect of the above­ named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. This document does not limit your ability to testify at deposition or trial about any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records,** or **any other matter bearing on his or her 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).
3. I understand that I have the right to revoke this authorization at any time. I understand that ifI 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 infonnation 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 two years from the date of execution.
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. Ifl have questions about disclosure ofmy 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:

Signature:

(plaintiff/representative)

Date: \_

### AUTHORIZATION TO DISCLOSE MEDICAID 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., 6000 Parkland Blvd., Mayfield Hts., OH,** any and all records containing Medicaid information, including those that may contain protected health information (Pill) regarding

 **«Namel»,** whether created before or after the date of

signature. Records requested may include, but are not limited to:

all Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospital, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of **«Namel»;** records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of (the earlier often years before the date of signature or 5 years before the date of any removal) to present.

Because this litigation 1s ongoing, it is essential that you preserve the original Medicaid records. Please take all steps that are necessary to preserve the Medicaid records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in ***In re: Davol, Inc.lC.R. Bard, Inc. Polypropylene Hernia Mesh Products Liability Litigation,* MDL 2:18- md-02846; U.S. District Court for the Southern District of Ohio,** including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

**NOTICE**

* **The individual signing this authorization bas the right to revoke this authorization at any time, but shall provide a copy of the revocation to Reed Smith LLP and/or Litigation Management Inc., except to the extent that the entity has already relied upon this** Authorization to disclose protected health information **(PHI).**

## The individual signing this authorization understands 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.

The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI will no longer be protected by 45 CFR Section 164, Subpart E.

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **Litigation Management Inc.**

Signature Name

 Fonner/Alias/Maiden Name Date

Date ofBirth

Social Security Nwnber

Address

Social Security Administration

Consent for **Release** of Information

Instructions for **Using** this Form

Form Approved

0MB No. 0960-0566

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, toan 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 administrationof a program under the Social Security Act.

**NOTE:** Do not use this form to:

* Request the release ofmedteal 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 onlfne at [www.ssa.gov/online/ssa-7050.pdf.](http://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 torelease 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 youor to process your request to release your records toa 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 torespond to requests for SSA records information. However, thePrivacy 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 notlimited 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-fundedor 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 Soclal**

**Security office through SSA's website at** [www.socialsecurity.gov.](http://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 1-800-325 778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send lH1lY comments relating toour time estimate to this address, not the completed form.***

**Fonn SSA-3288** (11-2016) uf

Destroy Prior Editions

Social Security Administration

**Consent for Release of Information**

Form Approved

**0MB No.** 0960-0566

You must complete all required fields. We will not honor your request unless all required frelds are completed. *(\*Slgnffles 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 \*My Soclal Security Number (MM/DD/YYYY}**

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 PacketlD number found above SocialSecurity 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 infonnation selected from the list below:**

**Check at least one box. We will not disclose records unless you include date ranges where applicable.**

1. D Verification of Social Security Number
2. D Current monthly Social Security benefit amount
3. D Current monthly Supplemental Security Income payment amount
4. [x] My benefit or payment amounts from date todate PRESENT.
5. 00 My Medicare entitlement from date todate PRESENT.
6. D Medical records from my claims folder(s) from date. todate.

Ifyowuant us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.

1. 00 Complete medical records from my claims folder(s)
2. 00 Other record(s) from my file (Wewill 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.)

 Documenls or other ttems relaOng to my socialsecurity claims(s): applications, petitions, payment documenls/decislons/awards/denlals, jurisdictlonaldocuments/notes,

transcripts, correspondence, notice of hearings, hearing records, orders, depositiom;, reports;wi1nesses, medical reviewers and experts consultative examination reports, medical records anddetermination records.

I **am the Individual, to whom the requested infonnatlon 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 theinformation 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 punlshable by a fine of up to**

$5,000. I also understand thatI must pay all applicable fees for requesting information for a non-program-relatedpurpose.

**\*Signature: \*Date:**

**-Address: -Daytime Phone:**

**Re**Iati**onship (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) |

**Fonn SSA-3288** (11-2016) uf

### AUTHORIZATION TO DISCLOSE INSURANCE 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., 6000 Parkland Blvd., Mayfield Hts., OH,** any and all records containing insurance information, including those that may contain protected health information (PHI) regarding

**«Namel»,** whether created before or after the date of signature. Records requested may include, but are not limited to:

applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of the past 10 years.

Because this litigation is ongoing, it is essential that you preserve the original insurance records. Please take all steps that are necessary to preserve the insurance records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in ***In re: Davol, Inc.lCR. Bard, Inc. Polypropylene Hernia Mesh Products Liability Litigation,* MDL 2:18- md-02846; U.S. District Court for the Southern District of Ohio,** including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

**NOTICE**

**The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to Reed Smith LLP and/or Litigation Management Inc., except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**

* **The individual signing this authorization understands 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.**

**The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that,** in **such case, the disclosed PHI will no longer be protected by 45 CFR Section 164, Subpart E.**

I have read the foregoing Authorization and understand that it will permit the entity identified above

to disclose PHI to **Litigation Management** Inc.

Signature Name

Date

Former/Alias/Maiden Name Date of Birth

Social Security Number

Address

**RVICES**

**QCNTHS fMOR MEDSICARE** &**MfDICAIDSE**

**Medicare**

Beneficiary Services:1-800-MFDICARE(1-800-633-4227)

TTY/ IDD:1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access toyour personal health infurmatbn.

**Where to Return Your Completed Authorization Fonns:**

After you complete and sign the authorization fumi, return it to the address below:

**Medicare CCO, Written Authorization Dept. P0Box1270**

**Lawrence, KS 66044**

**For New York Medicare Beneficiaries ONLY**

The New York State Public Heahh Law protects infunnatbn that reasonably could identify someone as having HIV symptoms or inrecfun, and infunnation regarding a person's contacts. Because ofN ew York's Jaws protecting the privacy of infunnatbn related to alcohol and drug abuse, mental heahh treatment, and HIV, there arespecial instructions fur how you, as a New York resident, should complete this funn.

* For quesfun 2A,check the box fur *Limited Information,*even if you want to authorize Medicare to release any and all of your personal heahh infunnation.
* **Then proceed to question 2B.** You may also check any of the remaining boxes and include any additional limitations in the space provided. For example, you could write ''payment information".

**Instructions for Completing Section2C of the Authorization Form:**

*Please select one of the following options.*

* **Option 1 To include** all infunnation, check thebox:"All infurmatbn, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the funn.
* **Option 2 To exclude** the infunnation listed above, check thebox''Exc1ude infunnation about alcohol and drug abuse, mental health treatment, and HIV". Then proceed with the rest of the funn.

If you have any questions or need addifunal assistance, please reel free to call us at 1-800- MEDICARE (1-800-633-4227). TIY users should call 1-877-486-2048.

# Sincerely,

1-800-MEDICARE

Customer Service Representative

Encl

Department of Heallh and Human Services Centers for Medicare &Medicaid Services

FOITTI Approved OMS No. 0938-0930

Expiration Date: 6/30/2021

**Information to Help You Fill Out the**

**"1--800-MED**I**CAREAuthori7.ation to Disclose Personal HealthInformation" Form**

By law, Medicare must have your written permission (an ''authorization') to use or give out your personal medical infunnation fur any pmpose that :isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ('4revoke') your written pennission at any time, except if Medicare has aJready acted based on your pennission.

If you want 1-800-MEDICARE to give your personal health infunnatim to someone other than you, you need to let Medicare know in writing.

If you arerequesting personal health infonnation fur a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request fur information. (For example: Executor/Executrix papers, next ofkin attested bycourt documents with a court stamp and a judge's signature, a Letter ofTestamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please exp1ain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections ofthe furm to ensure timely processing.

1. Print the name of the person with Medicare.

Print the Medicare mmlber exactly as it :is shown on the red, white, and blue Medicare card.

Print the birthday in m:mth, day, and year (mm/dd/yyyy) of the person with Medicare.

1. This section tells Medicare what personal health informatim to give out. Please check a box in 2A to indicate how much infurmation Medicare can disclose. If you only want Medicare to give out limited infurmation (fur example, Medicare eligibility), also check the box(es) in 2B that apply to the type of information you want Medicare to give out. Box 2C must be completed by **NewYork Residents.**
2. This section te1ls Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.
3. This section te1ls Medicare the reason fur d:isclosme.
4. Medicare will give your personal health information to the person(s) ororganization(s) you fill in here. You may :fill in more than one person or organization.

If you designate an organization, you must also identify one or more individuals in that

Form CMS-10106 (Rev 06/18)

Instructions

Depar1ment ofHeal1h and Human Services Centers r Medicare &Medicaid Services

organization to whom Medicare may cmchse your personal heah:h information.

Form Approved 0MB No. 0938-0930

Expiration Date: 6/30/2021

1. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

If you are a personal representative of the person with Medicare, check the box, provide your address and phone mnnber, and attach a copy of the paperwork that shows you can act fur that person (fur example, Power of Attorney).

1. Send your completed, signed authori2ation to Medicare at the address shown here on your authori2ation funn.
2. If you change your mind and don't want Medicare to give out your personal heah:h infonnation, write to the address shown tmder number seven on the authori2ation furm and tell Medicare. Your letter will revoke your authori2ation and Medicare will no hnger give out your personal heah:h information (except fur the personal health infunnation Medicare has a1ready given out based on your pennission).

You should make a copy of your signed authori2ation fur your records before mailing it to Medicare.

Form CMS-10106 (Rev 06/18)

Instructions

Department of Health and Human Services Centers for Medicare &Medicaid Services

Form Approved 0MB No.0938-0930

Expiration Date: 6/30/2021

**1-800-MEDICARE Autho:rimtion to Disclose Personal Health Information**

Use this funn if you want 1-800-MEDICARE to give yom personal health information to someone other than you.

1. **Print Name**

(First and last name of theperson with Medicare)

**Medicare Number**

(Exactly as shown on the Medicare Card)

**Date ofBirth**

(mm/dd/yyyy)

1. Medicare will only disclose the personal health information you want disclosed.

**2A: Check only .2!!£\_box below to tell Medicare the specific personal health information you want disclosed:**

D Limited Information (go to question 2b)

D Any Information (go to question 3)

**2B: Complete only** if **you selected "limited information". Check all that apply:**

D Information about yom Medicare eligibility

D Information about yom Medicare claims

D Information about plan enrolhnent (e.g. drug or MA PJan)

D Information aboutpremium payments

D Other Specific lnfunnation (please write below; fur example, payment information)

**2C: NY Residents Only,** this section must be completed.

Please select one of the following options: (Please check only one box.)

D Include all information. This includes information about alcohol and drug abuse, mental health treatment, and JilV.

# OR

Form CMS-10106 (Rev 06/18}

Department of Health and Human Services Cenlersb Medicare &Medicaid Services

Form Approved 0MB No. 0938-0930

Expiration Dale: 6/30/2021

D Exclude infunnation about alcohol and drug abuse, mental health treatment, and HIV

1. **Check only one box belowindicating how long Medicare can use this authorization to disclose your penonal health information** (subject to applicable Jaw-fur example, your State may limit how hng Medicare may give out your personal heahh infunnation):

D Disclose my personal health infunnation indefinitely

I I Disclose my personal heahh infunnation fur a specified period only

beginning: (mm/dd/yyyy) and ending: (mmldd/yyyy)

1. **Fill** in **the reason for the disclosure (youmay write "at my request"):**

to be used in support of active litigation.

**S. Fill** in **the name and address of the person or organization to whom you want Medicare to disclose yourpersonal health information. Please provide the specific name of the person for any organization you list below.** If **you fflJuld like to authoritt any additional individuals or organizations, please add those** to **the back of this fonn.**

## Name Litigation Management Inc.

Address 6000 Parkland Blvd., Mayfield Heights., OH 44124

Name

Address

Form CMS-10106 (Rev06/18)

Deparbnent of Heal1h and Human Services Centers for Medicare &Medicaid Services

Form Approved 0MB No. 0938-0930

Expiration Date: 6/30/2021

**Note: You have the right to take back ("revoke")yourauthori7.ation at any time,** in **writing, except to the extentthat Medicare has already actedbasedon your pennission. To revoke authori7.ation, senda written requestto the address notedbelow.** Your authomation or refusal to authoriz.e disclosure of your personal health infonnation will have no e:frect on your enrolhnent, eligibility fur benefits, or the arnmmt Medicare pays fur the health services you receive.

I **authori7.e 1-800-MEDICAREto disclose mypersonal health information listedabove to the person(s) or organimtion(s)** I **have named on this form.** I **understand that my personal health information may be re-disclosed by the person(s) or organimtion(s) and may no longer be protected by law.**

Signature

Telephone Number

Date(mm/dd/yyyy)

**Print the address of the person with Medicare (Street Address, City, State, and ZIP)**

DCheck here if you aresigning as a personal representative and complete below.

P1ease attach the appropriate documentation (fur examp1e, Power of Attorney). This

applies if someone other than the person with Medicare signed above.

**Print the Personal Representative's Address (Street Address, City, State, and ZIP)**

Telephone Nwnber of Personal Representative:

Personal Representative's Relationship to the Beneficiary:

6.

Form CMS-10106 (Rev 06/18)

Department ofHeallh and Human Services Centers for Medicare &Medicaid Services

Form Approved

0MB No. 0938-0930

Ex piraion Dale: 6/30/2021

7 **Send the completed, signedauthorimtion to:**

Medicare CCO, Written Authorization Dept.

PO Box 1270

Lawrence, KS 66044

**Print Form**

**Note:** You have tre right to take back ("revoke') yom authorizafun at any time, in writing, except to the extent that Medicare has already acted based on yom permission If you would like to revoke authorization, send a written request to the address noted above.

Your authorization or refusal to authorize disclosure of your personal health :infunnation will have no effect on your enrolhnent, eligibility fur benefits, or the amount Medicare pays fur the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are reqwred to respond to a collecfun of infunnation unless it disp1ays a valid 0MB control number. The valn 0MB control number fur this infunnatim collecfun is 0938-0930. The time reqwred tocomp1ete this infurmation collecti:>n is estimated to average 15 minutes per response, including the time to re w instrucfuns, search existing data resources, gather the data needed, and comp1ete and review the infurmation collecfun If you have comments concerning the accuracy of the time estimate(s) orsuggestions fur improving this :form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltilmre, Maryland 21244-1850.

Form CMS-10106 (Rev06/18)

**AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION**

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian ofRecords at the above-named entity to disclose to **Litigation Management Inc., 6000 Parkland Blvd., Mayfield Hts., OH,** any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding **«Nam.el»,** whether created before or after the date of signature. Records requested may include, but are not limited to:

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 the past 10 years.

Because this litigation is ongoing, it is essential that you preserve the original workers' compensation records. Please take all steps that are necessary to preserve the workers' compensation records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in ***In re: Davol, Inc.lCR. Bard, Inc. Polypropylene Hernia Mesh Products Liability Litigation,* MDL 2:18- md-02846; U.S. District Court for the Southern District of Ohio,** including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

**NOTICE**

* **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to Reed Smith LLP and/or Litigation Management Inc., except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**

**The individual signing this authorization understands 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.**

* **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing**

the subject lawsuit, and that, in such cas thedisclosed PHI will no longer be protected by 45 CFR Section 164, Subpart E.

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **Litigation Management Inc.**

Signature Name

Date

Fonner/Alias/Maiden Name Date of Birth

Social Security Number

Address

**AUTHORIZATION TO DISCLOSE EMPLOYMENT 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., 6000 Parkland Blvd., Mayfield Hts., OH,** any and all records containing employment information, including those that may contain

protected health information (PHI) regarding  **«Namel»,**

whether created before or after the date of signature. Records requested may include, but are not limited to:

all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health and disability insurance plans. 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 (the earlier of ten years before the date of signature or *5* years before the date of any removal) to present.

Because this litigation is ongoing, it is essential that you preserve the original employment records. Please take all steps that are necessary to preserve the employment records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in ***In re: Davol, Inc.lC.R. Bard, Inc. Polypropylene Hernia Mesh Products Liability Litigation,* MDL 2:18-md-02846;**

**U.S. District Court for the Southern District of Ohio,** including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

**NOTICE**

* **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to Reed Smith LLP and/or Litigation Management Inc., except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
* **The individual signing this authorization understands 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.**

**The individual signing this authorization understands that protected health information (PHI)** disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI will no longer be protected by 45 CFR Section 164, Subpart E.

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **Litigation Management Inc.**

Signature Name

Date

Former/Alias/Maiden Name Date of Birth

Social Security Number

Address

### AUTHORIZATION TO DISCLOSE PSYCIDATRIC RECORDS AND PSYCHOTHERAPY NOTES 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., 6000 Parkland Blvd., Mayfield Hts., OH,** any and all psychiatric records and psychotherapy notes records, including those that may contain protected health information (Pill) regarding  **«Namel»,** whether created before or after the date of signature. Records requested may include, but are not limited to:

complete copies of all psychiatric records and psychotherapy notes reports, therapist's notes, social worker's records, all medical records, physicians' records, surgeons' records, pathology/cytology reports, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, records of drug abuse and alcohol abuse, physicals and histories, nurses' notes, correspondence, insurance records, consent for treatment, statements of account, itemized bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning the physical or mental condition of this patient, or documents containing information regarding amendment of protected health information (PHI) in the medical records. 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.

Because this litigation is ongoing, it is essential that you preserve the original medical records, radiology, pathology/cytology slides, tissue/cell blocks, and any recut slides that are in your possession, as an expert may need to examine these slides and blocks in the future. Please take all steps that are necessary to preserve the medical records, radiology films, slides and blocks, and any recut slides that remain in your possession.

**To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants. This document does not authorize you to discuss with any individual any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. This document does not limit your ability to testify at deposition or trial about any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition.**

I do not authorize any *ex parte* verbal/oral communication concerning the subject matter of this authorization.

Unless revoked in writing, this authorization shall be valid for the period of litigation in ***In re: Davol, Inc./C.R. Bard, Inc. Polypropylene Hernia Mesh Products Liability Litigation,* MDL 2:18- md-02846; U.S. District Court for the Southern District of Ohio,** including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

* **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to «Firm» and/or «ThirdParty\_Vendor», except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
* **The individual signing this authorization understands 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.**
* **The individual signing this authorization understands that protected health information (PID) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth** in **the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed Pill will no longer be protected by 45 CFR Section 164, Subpart E.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose my PHI, including psychiatric records and psychotherapy notes records and information, to **Litigation Management Inc.** I further understand that records pertaining to psychiatric records and psychotherapy notes information may be specifically protected by federal and/or state regulations; by signing this authorization I am allowing the disclosure of any psychiatric records and psychotherapy notes infonnation held by the entity identified above.

Signature Name

Date

Fonner/Alias/Maiden Name Date of Birth

Social Security Number

Address