If IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

IN RE: PARAGARD IUD PRODUCTS LIABILITY LITIGATION	))))	MDL DOCKET NO. 2974 (1:20-md-02974-LMM) This Document Relates to All Cases

AMENDED CASE MANAGEMENT ORDER REGARDING PLAINTIFF FACT SHEETS AND PFS DOCUMENT PRODUCTION

The Court hereby issues this Case Management Order to govern the form, procedure, and schedule for the completion and service of Plaintiff Fact Sheets ("PFS"), and other documents referenced therein, and the process for addressing deficient and delinquent PFSs. The form PFS is attached hereto as Exhibit A, with exhibits thereto attached as Exhibits A-1 through A-8.

I. PLAINTIFF FACT SHEET

A. SCOPE

This Order applies to all Plaintiffs and their counsel in: (a) all actions transferred to *In re Paragard IUD Product Liability Litigation* ("MDL No. 2974") by the Judicial Panel on Multidistrict Litigation ("JPML") pursuant to its Order of December 16, 2020 (Doc. No. 60); (b) all related actions originally filed in or removed to this Court; (c) any "tag-along" actions transferred to this Court by the JPML pursuant to Rules 6.2 and 7.1 of the Rules of Procedure of the JPML; and all

actions directly filed into MDL No. 2974 pursuant to the Case Management Order Regarding Direct Filing [Doc. No. 129] (collectively, "Member Actions"). The questions in the PFS and the corresponding document requests shall be answered and responded to without objection.

B. DEADLINES AND SERVICE OF A PFS AND RELATED MATERIALS

1. Cases Currently Pending in MDL No. 2974. Each Plaintiff in a Member Action pending in MDL No. 2974 on the date of entry of this Order shall have one hundred twenty (120 days from the date of entry of this Order to serve a fully executed and complete PFS (as defined in Sections C.2 and C.3 below) and duly executed authorizations, with the relevant documentation, as set forth in Section F below.[1]

2. Cases Transferred by the JPML to MDL No. 2974 after the Entry of this Order. Each Plaintiff in a Member Action not pending in MDL No. 2974 on the date of entry of this Order, but which thereafter is transferred by the JPML to MDL No. 2974, shall have one hundred twenty (120) days from the date his/her individual action is docketed in MDL No. 2974 to serve a fully executed and

[1] To the extent applicable, each Plaintiff in a Member Action pending in MDL No. 2974 as of July 7, 2022, has 30 additional days from the date of this order to serve an executed Medicaid authorization pursuant to Section F(6) of this order. The relevant Medicaid authorization(s) are now attached to this order as Ex. A-6.

complete PFS (as defined in Sections C.2 and C.3 below), and duly executed authorizations with the relevant documentation attached, as set forth in Section F below.

3. Cases Directly Filed in MDL No. 2974. Each Plaintiff in a Member Action not pending in MDL No. 2974 on the date of entry of this Order, but which thereafter is directly filed in MDL No. 2974 pursuant to the Case Management Order Regarding Direct Filing [Doc. No. 129], shall have one hundred twenty days (120) from the date his/her individual complaint is filed in MDL No. 2974 to serve a fully executed and complete PFS (as defined in Sections C.2 and C.3 below), and duly executed authorizations with the relevant documentation attached, as set forth in Section F below.

4. Transmission of PFS and Other Documents to Defendants. Plaintiffs shall complete and serve their PFS and documents responsive to the requests for production of documents set forth therein upon Defendants by uploading their PFS and documents responsive to the request for production of documents to Plaintiffs' vendor, Postlethwaite & Netterville ("P&N"). Plaintiffs' submission of a PFS to the P&N portal along with an e-mail notification sent to Defendants[2]

[2] The following individuals shall be included in the email notifications to Defendants: Fred Erny – ferny@ulmer.com; Gina Saelinger – gsaelinger@ulmer.com; Jena Gundrum - jgundrum@ulmer.com; Emily Bailey - ebailey@ulmer.com; Lori Cohen – CohenL@gtlaw.com;

automatically by the P&N portal and/or separately by the individual Plaintiff's counsel will effectuate service upon Defendants and the date of submission to the P&N portal will be deemed the effective date of service (PFS Date Submitted).[3] In the event of portal failure or technical issue, Defendants will notify the Plaintiffs' Steering Committee in writing of such. Within 7 days of such notice, the Plaintiffs' Steering Committee will inform P&N and request P&N to upload the submitted and served PFSs via ShareFile to Defendants. It is further ordered that the Plaintiffs' Steering Committee shall have access to all documents uploaded to Plaintiffs' vendor, P&N. All documents shall be produced in accordance with the requirements as set forth in the Case Management Order Regarding Production of Electronically Stored Information and Paper Documents ("ESI Protocol") [Doc. No. 128]. PDFs should be produced as searchable PDFs[4] with each facility's or provider's records

Allison Ng – nga@gtlaw.com; Mecca Brewer - brewerm@gtlaw.com; Tiffany Hardin - hardint@gtlaw.com; Jessica Ayarzagoitia - Jessica.Ayarzagoitia@Ontellus.com; Harmony Trevino - Harmony.Trevino@Ontellus.com; Jonathan Torres - jonathan.torres@ontellus.com; Sandra Penney - Sandra.Penney@Ontellus.com.

[3] Upon the signing of this order, Defendants and their vendor, Ontellus, will be provided access to the P&N Portal to view and download PFSs and produced documents, run real time reports (Submitted Fact Sheets Report and Fact Sheet Documents Report), and can search the portal by plaintiff name and/or date submitted and served. Individual Plaintiff's counsel and Defendants will receive e-mail notification from the P&N Portal when a PFS is submitted and served.

[4] Endorsement of such records with Bates-numbers is strongly encouraged, in the following format: a combination of an alpha prefix containing Plaintiff's last name first name, and the facility

contained in a separate PDF. The transfer of documents by Plaintiffs' vendor, P&N, to Defendants' vendor, Ontellus, in the aforementioned manner shall constitute effective service of the PFS and such records.

5. Extensions of PFS Deadlines. A Plaintiff may request one extension not to exceed thirty (30) days to serve a completed PFS, which Defendants shall not unreasonably withhold. Such requests must be made in writing via email to ParagardPFSExtensionRequest@ulmer.com before the expiration of the deadline. As the deadlines for Plaintiff Fact Sheets have been negotiated between the parties, requests for extension should be the exception, rather than the rule, and such requests should be made in good faith.

C. PFS GENERAL REQUIREMENTS AND EFFECT

1. PFS Form**.** The form PFS that shall be used in MDL No. 2974 and all Member Actions is attached hereto as Exhibit A, with Exhibits A-1 through A-8. The substance of Exhibits A and A-1 through A-8 may not be modified in any respect without the agreement of the Parties and approval of the Court; however, a Plaintiff may attach additional pages to respond to particular questions, if necessary and appropriate.

---

or provider name, along with an 8-digit number and to be numerically sequential for each facility or provider (*e.g.* SmithJane_Memorial_Hospital_00000001).

2. Items to be provided or produced. Plaintiffs in each Member Action shall provide or produce the following within the deadlines set forth in Section B above: (a) a PFS responding to all questions applicable to the Plaintiff therein; (b) a signed and dated Declaration Page; (c) the requested records and documents in response to the document requests set forth in the PFS as maintained by Plaintiff and his/her counsel (to the extent not subject to privilege and/or work-product protections); (d) duly executed authorizations to obtain discoverable records as described in Section F below, using the form authorizations attached to this Order as exhibits. The agreed manner of service on Defendants is set forth in Section B.4 above.

3. PFS that is complete. In responding to the PFS, each Plaintiff is required to provide a PFS that is complete. For a PFS to be "complete," the responding Plaintiff must comply in full with Sections C.2(a)-(d) above.

4. Deficiencies. Those Plaintiffs who serve a PFS, but who do not provide a complete PFS or who provide incomplete or deficient information, shall be governed by Section D below.

5. Delinquencies (i.e., No PFS Served). Plaintiffs who do not serve a PFS by the deadline set forth in Section B above, including any granted extension, shall be governed by Section E below.

6. Each Plaintiff shall remain under a continuing duty to supplement the information provided in the PFS pursuant to Fed. R. Civ. P. 26(e).

7. Each completed PFS, and the information contained therein, shall be verified, signed and dated by the Plaintiff(s) or the Plaintiff's representative as if they were interrogatory responses under Rule 33 or a response to a Request for Admission under Rule 36. All responses in a PFS or amendment thereto are binding on the individual Plaintiff as if they were contained in answers to interrogatories under Rule 33 or a response to a Request for Admission under Rule 36 and can be used for any purpose and in any manner that answers to interrogatories or responses to a request for admission can be used pursuant to the Federal Rules of Civil Procedure, subject to the confidentiality provisions of Section H below. The requests for production in the PFS shall be treated as document requests under Rule 34.

D. PFS DEFICIENCY PROCESS

1. PFSs Subject to Order to Show Cause Procedure for Incompleteness and/or Certain Deficiencies

a. If a Plaintiff fails to sign and date the Declaration page or does not provide duly executed Authorizations by the deadline set forth in Section B above, that Plaintiff is subject to the Order to Show Cause process in Section

D.1(d) below.[5]

b. If a Plaintiff provides excessive responses of "I don't know" or "To be determined," or leaves an excessive amount of responses to questions blank, that Plaintiff is subject to the Order to Show Cause process in Section D.1(d) below.

c. If a Plaintiff fails to produce responsive documents in her possession or control as identified in her PFS, that Plaintiff is subject to the Order to Show Cause process in Section D.1(d) below.

d. If any one or more of the above sections (a) through (c) apply, Defendant's counsel shall notify Plaintiff's attorney of record in writing via email and inform such Plaintiff that she has an additional fifteen (15) days to correct the deficiency(ies). If the deficiency(ies) are not cured in full within the 15 day period, Defendants may include the case on a request to the Court for an Order to Show Cause, which may include a request for dismissal of the case.

e. If any one or more of the above sections (a)-(d) apply to a Plaintiff, that Plaintiff may not proceed to any subsequent stages of case-specific

[5] To the extent applicable, each Plaintiff in a Member Action pending in MDL No. 2974 as of July 7, 2022, has 30 additional days from the date of this order to serve an executed Medicaid authorization pursuant to Section F(6) of this order and will not be subject to the Show Cause process in Section D.1(d) for not producing an executed Medicaid authorization pursuant to Section F(6).

discovery or be eligible for any further discovery "pools," including, but not limited to potential trial pools.

2. Other Deficiencies

a. A PFS that contains responses of "I don't know" or "To be determined" or in which responses to questions are left blank, but which do not amount to a good faith determination of "excessive," may still be considered deficient. In such case, Defendants may advise counsel for Plaintiff of those deficiencies, and the parties should meet and confer in good faith regarding supplementation by Plaintiff of the information.

b. The parties may agree that certain deficiencies need not be resolved until a later point. The failure to raise a deficiency(ies) does not waive or prejudice a Defendant's right to seek supplementation or provision of the information in response to a deficiency at a later time.

E. PFS DELINQUENCY PROCESS (i.e., NO PFS SERVED)

1. If a Plaintiff does not serve an executed PFS within the deadline set forth in Section B above, including any extension granted pursuant to Section B.5 above, Defendant(s) shall send a "Notice of Delinquency" letter via email to that Plaintiff's attorney of record, and the Plaintiff shall have thirty (30) days from the date of the Notice of Delinquency letter to serve an executed, complete PFS.

2. If the Plaintiff does not serve an executed, complete PFS by the expiration of the thirty (30) day period provided for in Section E.1 above, Defendants may include the case on a request to the Court for an Order to Show Cause, which may include a request for dismissal of the case.

3. A Plaintiff who is the subject of a Notice of Delinquency letter may not proceed to any subsequent stages of case-specific discovery or be eligible for any further discovery "pools," including, but not limited to potential trial pools.

4. A Plaintiff who is the subject of a Notice of Delinquency letter under Section E, or who is the subject a Notice of Deficiency letter under of Section D.1 above, is not prohibited from proceeding to any subsequent stages of case-specific discovery or from being eligible for any further discovery "pools," including, but not limited to potential trial pools, if such delinquencies and/or deficiencies are cured as agreed to by the Parties or as determined by the Court, and if such Plaintiff meets all other criteria for inclusion in such subsequent stages of case discovery or pools.

F. SPECIFIC REQUIREMENTS FOR AUTHORIZATIONS

1. Execution of Authorizations Generally.[6] Plaintiffs shall sign and date the Authorizations listed below setting forth the identity (name and full address) of the applicable custodian of the records or provider of care for any providers listed in her PFS. Those Authorizations shall be served on Defendants in the manner described in Section B.

2. Medical Authorizations. Each individual Plaintiff shall sign and date the "Limited Authorization to Disclose Health Information" attached as Exhibit A-1 for each health care provider or provider of healthcare services set forth in Plaintiff's Fact Sheet (including but not limited to those in sections III (A, D, E); IV (A-C), and V (C-J; L-N, R, and S)) and produce such Authorizations to Defendants by the deadline set forth in Section B above.

3. Psychological or Emotional Injury Authorizations. If a Plaintiff is asserting a claim for psychological or emotional injury, such Plaintiff shall provide to Plaintiff's counsel a signed and dated Authorization attached as Exhibit A-2,

[6] In negotiating the Production of Documents and Things and Document Requests, which begin on page 43 of the Plaintiff Fact Sheet, Defendants agreed to withdraw Request No. 10 in exchange for the agreement of reciprocity. That is, the parties agree, and embody their agreement here, that any discovery request, except for Document Request No. 9, in the PFS containing "to the extent not already produced" or similar language, will be deemed repetitive. In addition, the parties agreed to delete Request No. 11, seeking production from Plaintiffs of the Paragard including any and all pieces, to be addressed in a product inspection protocol to be negotiated later, if necessary.

which Plaintiff or Plaintiff's counsel shall complete with regard to any Health Care Provider who treated Plaintiff for such injury and any Health Care Facility in which the Plaintiff was treated for such injury (including, but not limited to, as set forth in Plaintiff's Fact Sheet, Sections IV C; and V (L-M). Plaintiff's counsel shall provide such Exhibit A-2 Authorizations to Defendants' Counsel within the deadline set forth in Section B above. If a Plaintiff is not asserting a claim for psychological or emotional injury, the Plaintiff does not need to complete the Authorization attached as Exhibit A-2.

4. Employment and Tax Authorizations. If a Plaintiff is asserting a claim for lost wages or lost earnings or lost earning capacity, then such Plaintiff shall provide to Plaintiff's counsel a completed, signed and dated Authorization for the release of employment records for any employer listed in Plaintiff's Fact Sheet, in the form attached as Exhibit A-3 and a signed and dated Authorization for the release of tax records, in the form attached as Exhibit A-4. Plaintiff's counsel shall provide Exhibit A-3 and A-4 Authorizations to Defendants' Counsel within the deadline set forth in Section B above. If a Plaintiff is not asserting a claim for lost wages or lost earnings or lost earning capacity, the Plaintiff does not need to complete the Authorization attached as Exhibits A-3 and A-4.

5. Insurance Authorizations. Each individual Plaintiff shall sign and date the Authorization for the release of insurance records for any insurer listed in Plaintiff's Fact Sheet, in the form attached as Exhibit A-5 and produce such Authorizations to Defendants by the deadline set forth in Section B above.

6. Medicare/Medicaid Authorizations. If a Plaintiff has been covered by Medicare or Medicaid at any time, such Plaintiff shall sign and date the Authorization for the release of Medicare/Medicaid records, in the form attached as Exhibit A-6 and produce such Authorization to Defendants by the deadline set forth in Section B above.

7. Workers' Compensation and Disability Authorizations. If a Plaintiff has applied for or been awarded workers' compensation or disability benefits at any time in the past 12 years, such Plaintiff shall provide to Plaintiff's counsel a signed and dated Authorization for the release of workers' compensation records, in the form attached as Exhibit A-7, and/or the Authorization for the release of disability records, in the form attached as Exhibit A-8, as applicable. Plaintiff's counsel shall provide such Exhibit A-7 and Exhibit A-8 Authorizations to Defendants' Counsel within the deadline set forth in Section B above. If a Plaintiff has not applied for or been awarded either workers' compensation or disability, that Plaintiff need not complete either Authorization.

8. Records Custodians Not Listed in PFS. For any custodian of records not listed in the Plaintiff's Fact Sheet, Defendants may request that Plaintiff complete, sign and date a specific Authorization so that Defendants (or their record collection vendor) may obtain records from that custodian. Plaintiffs' counsel must provide such authorizations within fourteen (14) days of the written request. Plaintiff's counsel may seek an extension of up to fourteen (14) additional days for good cause in which to supply said Authorization and Defendants' consent shall not be unreasonably withheld. If the requested authorization is not provided within fourteen (14) days or after any extension, Defendants may include the case on a request to the Court for an Order to Show Cause, which may include a request for dismissal of the case.

9. Custodian-Specific Authorizations. Plaintiff's counsel shall provide to Defendants duly executed custodian-specific authorization(s) if requested or required by a particular custodian, within fourteen (14) days of receipt of notice by Defendants (or their record collection vendor) that such custodian-specific authorization is requested or required. Plaintiff's counsel may seek an extension of up to fourteen (14) additional days for good cause in which to supply said Authorization and Defendants' consent shall not be unreasonably withheld. If the requested authorization is not provided within fourteen (14) days or after any

extension, Defendants may include the case on a request to the Court for an Order to Show Cause, which may include a request for dismissal of the case.

10. Additional Authorizations. To the extent additional custodian authorizations are requested by Defendants, Plaintiff's counsel shall cooperate in providing them within a reasonable time.

G. VOLUNTARY DISMISSALS

This Order shall in no way prohibit or inhibit a Plaintiff or her counsel from filing stipulations for or motions to dismiss a specific defendant or defendants, or of an entire Plaintiff's case, for those Plaintiffs who are unable to comply with the requirements set forth in this Order.

H. CONFIDENTIALITY

All information disclosed in a PFS, the PFS itself, and all related documents (including health care records and information) produced pursuant to the PFS or from the authorizations provided therewith shall be deemed confidential and treated as "Confidential Information" as defined in the Agreed Protective Order [Doc. No. 36].

SO ORDERED this 10th day of November, 2022.

Leigh Martin May
United States District Judge

Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

IN RE: PARAGARD IUD PRODUCTS LIABILITY LITIGATION	:	**MDL Docket No. 2974**
	:	
	:	**(1:20-md-02974-LMM)**
	:	
	:	**This Document Relates to All Cases**
	:	

PLAINTIFF FACT SHEET

Each plaintiff in MDL No. 2974 must complete this Plaintiff Fact Sheet ("PFS"). If You are completing this PFS in a representative capacity for someone who has died or who otherwise cannot complete the PFS, please answer as completely as You can for that person.

In completing this PFS, You are under oath and must provide information that is true and correct to the best of Your knowledge, and Your answers must be as complete as the information reasonably available to You permits. If You cannot recall all of the details requested, please provide as much information as You can. If the answer is "not applicable" or "none," please write that answer, rather than leaving the answer blank. If there is any information You need to complete any part of the Fact Sheet that is in the possession of Your attorney(s), please consult with Your attorney(s) so that You can fully and accurately respond to the questions in this Fact Sheet.

You must supplement Your responses if You learn that they are incomplete or incorrect in any respect. If You do not have knowledge sufficient to respond fully to a request or question after making a good faith and reasonable effort to obtain the relevant information, You must so state.

The parties, through their respective counsel, have agreed to limit the scope of the information and documents being requested from plaintiffs at this time to that which is set forth in this PFS. However, You are under an ongoing obligation to preserve any written or electronically stored information potentially relevant to the issues in this litigation, including but not limited to written and electronic correspondence, including e-mails, text messages, voicemails and blog postings, and content from all online social networking website accounts in existence since the date You/Plaintiff first had a Paragard placed in You to the present related to Your/Plaintiff's physical condition, physical activity, mental and/or emotional state, medical or health issues, economic or employment issues, Paragards in particular, IUDs in general, contraceptives in general, gynecological procedures, and/or Your lawsuit.

If You have any documents, including, but not limited to: packaging, labeling, or instructions for a Paragard; materials or items that You are requested to produce as part of answering this PFS; or materials that relate to the injuries, claims, and/or damages that are the subject of Your lawsuit, You must NOT dispose of, alter, or modify those documents or materials

in any way. You are required to give all of those documents and materials to Your attorney as soon as possible. If You are unclear about these obligations, please contact Your attorney.

The parties, by counsel, agree that the questions and requests for documents contained in this PFS are not objectionable and shall be answered without any objection. Further, it is agreed that Defendants do not waive the right to request additional information or documents by way of a supplemental fact sheet, interrogatories, requests for production of documents, and/or requests for admission. The parties, by counsel, also agree that You have the right, and ongoing duty, to supplement the responses to this PFS should You obtain or learn of additional responsive information and/or materials.

Information provided in response to this PFS will be used only for purposes related to this litigation and may be disclosed only as permitted by the Protective Order in this litigation. This PFS is completed pursuant to the Federal Rules of Civil Procedure. Your responses to the PFS shall be treated as answers to Rule 33 interrogatories and Rule 34 requests for production of documents, and are subject to the requirements of the Federal Rules of Civil Procedure and the applicable Local Rules.

You may attach as many sheets of paper as necessary to answer these questions.

DEFINITION OF TERMS

1. "Paragard" shall mean the Paragard Intrauterine Device(s) ("IUD") that was/were placed in You.

2. The terms "You" and "Your" or "Plaintiff," unless otherwise defined in a particular question, shall mean the person who had a Paragard placed.

3. The term "Lawsuit" shall mean the individual lawsuit that Plaintiff has filed and which is now part of MDL No. 2974.

4. When referring to a person, "identify" means to give, to the extent known, the person's full name, present or last known address, telephone number, and relationship to You.

5. The term "Health Care Provider" or "HCP" includes, but is not limited to, medical doctors, physicians, nurses, physician assistants, nurse practitioners, midwives, chiropractors, osteopaths, psychologists, psychiatrists, mental health providers, therapists, social workers, pharmacists, counselors, individuals affiliated with any religious group, and any individual or group who provided any diagnosis, care, treatment, therapy, counseling, and/or advice.

6. The term "Health Care Facility" includes, but is not limited to, hospitals, clinics, doctors' offices, infirmaries, out-patient facilities, offices, laboratories, pharmacies, substance abuse treatment centers, employment health care facilities, and all other locations at which medical care, counseling, therapy, testing, pain management, or medication is provided by any Health Care Provider.

I. GENERAL INFORMATION OF PERSON COMPLETING THIS FACT SHEET

A. Your full name: _____ ____ _____

B. State the following for the Lawsuit You filed:

C. Case Caption: _____

D. MDL Case No: _____

E. The name and contact information of the principal attorney(s) representing You:

_____
Name

_____
Firm

_____
Address

_____
Telephone Number

_____
E-mail Address

F. Are You are completing this PFS in a representative capacity?

◯ Yes ◯ No

If yes, provide the following information:

1. Your name: _____

2. Your address: _____

3. The name of the individual or estate You are representing, and in what capacity You are representing the individual or estate:

_____

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

4. If You were appointed as a representative by a court, the court and date of appointment:

_____ _____
Court Date of Appointment

5. Your relationship to the Plaintiff on whose behalf You are completing this PFS:

_____

6. If You represent a decedent's estate, state the date and place of the decedent's death:

_____ _____ _____

The remainder of this PFS requests information about the person who alleges injury from a Paragard. If You are completing this PFS in a representative capacity, please respond to the remaining questions with respect to the person who allegedly was placed with a Paragard, unless the question instructs You otherwise. Questions using the term "You" or "Your" refer to the person who allegedly was placed with the Paragard, unless instructed otherwise.

II. PERSONAL INFORMATION FOR THE PERSON WHO WAS PLACED WITH THE PARAGARD

A. Full name (first, middle and last): _____ ___ _____

B. Date of Birth (MM/DD/YYYY): _____

C. Place of Birth (CITY/STATE): _____ _____

D. Social Security Number: _____

E. Medicare Number: _____

F. Medicaid Number: _____

G. Maiden name or other names used or by which You have been known, and the date(s) You were known by those other names:

Maiden or other name	Dates known by that name (MM/DD/YYYY) to (MM/DD/YYYY)

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

H. Current Address:

_____ _____ _____ _____

Address City

State Zip

1. Who lives with You at this address?

Name of Person who lives with you	Relationship to You

2. How long have You lived at that address? _____ Years _____ Months

I. List all prior addresses for the time period beginning five (5) years prior to when You first had a Paragard placed and the dates when You lived at each of those addresses.

Prior Address	Prior City	Prior State	Prior Zip	Dates You lived at that address (MM/YYYY to MM/YYYY)

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

J. Gender (assigned at birth): ◯ Male ◯ Female

Prefer to self-identify as: _____

K. Beginning with high school and continuing through Your highest level of education, identify each school, college, university and/or other educational institution You have attended, the dates of attendance, courses of study pursued, diplomas or degrees awarded:

Name of School	City/State	Degree awarded; area of study or major	Dates of Attendance (MM/YYYY to MM/YYYY)

L. If You are, or have ever been, married, provide the following information:

Name and current address of Spouse	Dates of Marriage (MM/DD/YYYY to MM/DD/YYYY)	Reason for End of Marriage, if applicable (e.g., divorce, death, etc.)

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

M. For each child you have given birth to, provide the following information (for any child given up for adoption, just provide initials (rather than name) and date of birth).

Name of Child (First & Last)	Date of Birth (MM/DD/YYYY)	Child's Current Address

N. List each pregnancy You had that did not result in a live birth, the date such pregnancy ended, and the reason such pregnancy ended (e.g., miscarriage, abortion, still birth, etc.).

Date pregnancy ended (MM/YYYY)	Reason pregnancy ended

O. Employment Information

1. Are You currently employed?

◯ Yes ◯ No

2. If You are currently employed, provide the following information regarding Your current employer:

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

a. Name of Employer: _____

b. Address: _____

c. Dates of Employment: _____

d. Occupation/Job: _____

3. If You are not currently employed, did You leave Your last job for a medical reason?

◯ Yes ◯ No

If yes, describe when and why You left Your last job:

4. Provide the following information for each employer You have had for the time period from 5 years prior to the placement of your ParaGard to 3 years after Your ParaGard was removed (other than Your current employer):

Name of Employer	City, State of Employer	Dates of Employment	Occupation	Salary/Weekly Wage

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

5. Since your Paragard was placed through the present, have You been out of work for more than 30 days during any calendar year for reasons related to Your physical and/or mental health?

◯ Yes ◯ No ◯ Do not recall

If yes, provide the following information:

Name of Employer	Dates out of work (MM/YYYY to MM/YYYY)	Brief description of physical or mental health condition

P. Military Service Information

1. Have You ever served in any branch of the U.S. Military?

◯ Yes ◯ No

2. If yes, provide the following information:

a. the branch and dates of service, rank upon discharge, and type of discharge received:

Branch	Dates of service	Rank upon discharge	Type of discharge

b. Were You ever rejected or discharged from the military for any reason relating to Your medical, physical, psychiatric or emotional condition(s)?

◯ Yes ◯ No

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

c. If yes, state the condition(s) for which You were rejected or discharged:

Q. Insurance/Claim Information

1. Identify each insurance carrier with whom You had health insurance coverage, or that covered You, for the time period beginning two (2) years before Your Paragard was placed to the present time:

Insurance provider name and address

2. Have You filed a workers' compensation claim within the time period beginning two (2) years before Your Paragard was placed to the present?

◯ Yes ◯ No

If yes, for each claim please state the year you filed the claim(s) and the nature of the claimed injury/disability:

Year claim filed	Nature of the claimed injury/disability

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

3. In the time period beginning two (2) years before Your Paragard was placed to the present, have You ever applied for Social Security and/or state or federal disability, received Medicare, Medicaid, DOD Tricare, State Children's Health Insurance Program (SCHIP), Veterans Health Administration (VHA), or Indian Healthcare Services (IHS)?

◯ Yes ◯ No

If yes, identify the benefits received (check all that apply):

☐ Medicare
☐ Medicaid
☐ DOD Tricare
☐ State Children's Health Insurance Program (SCHIP)
☐ Veterans Health Administration (VHA)
☐ Indian Healthcare Services (HIS)

a. If yes, are You receiving those benefits now?

◯ Yes ◯ No

Please note: if You are not currently a Medicare – eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, You must supplement Your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. §1395y(b)(a), also known as Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and §1395y(b)(2) also known as the Medicare Secondary Payer Act.

R. Have You ever filed a lawsuit or made a claim or demand for compensation, other than in the present Lawsuit, relating to any bodily or personal injury(ies)?

◯ Yes ◯ No

If yes, provide a brief description of your injuries and the outcome of your lawsuit, claim, or demand.

S. Have You settled or reached any agreement, deal, or understanding of any kind with any other person, firm, corporation, or party with respect to Your lawsuit or the events described in Your lawsuit, including, but not limited to "Mary Carter" agreements?

This question seeks information concerning agreements or understandings of any kind whatsoever, including past, present, and future settlements, deals, agreements,

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

understandings, and conduct regarding the giving, withholding of, or nature of testimony or evidence.

◯ Yes ◯ No

If yes, provide the following information:

Names of Parties Involved	Date of settlement or agreement

T. Have You ever filed for bankruptcy?

◯ Yes ◯ No

If yes, provide the following information:

City and state where bankruptcy was filed	Date of filing (MM/DD/YYYY)	Case Number (if known)	Current Status

U. In the last 10 years, have You ever been convicted of, or pled guilty to, a felony and/or crime of fraud or dishonesty?

◯ Yes ◯ No

If yes, provide the following information:

State in which You were convicted or pled guilty	State or federal court?	Felony or crime for which You were convicted or with respect to which You pled guilty

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

III. PLACEMENT and REMOVAL OF PARAGARD

A. For each Paragard that has ever been placed in You, provide the following information:

Date of Placement (MM/DD/YYYY)	Lot number of the Paragard	Name of HCP who placed the Paragard	Address of HCP who placed the Paragard	Why did you choose Paragard?

Did You obtain Your Paragard from anyone other than the Health Care Provider who placed Your Paragard?

◯ Yes ◯ No

If yes, identify from what person and source You obtained Your Paragard:

B. **For each Paragard You listed in response to III(A) above**, provide the following information:

1. Oral, verbal, or spoken information conveyed to you (this includes, but is not limited to, information about risks, benefits, instructions for use, or any side effects and/or any warnings) [Include response for each Paragard You had placed.]:

Date of Placement (MM/DD/YYYY)	Did anyone provide information to You about Paragard before it was placed in You? (State Yes, No, or Do not recall)	Name of person who provided the information to You	What information were you told?

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

	◯ Yes ◯ No ◯ Do Not Recall		
	◯ Yes ◯ No ◯ Do Not Recall		
	◯ Yes ◯ No ◯ Do Not Recall		

2. Written information given to you (including but not limited to, for example, a pamphlet, a booklet, an information sheet, something else?) [Include response for each Paragard You had placed.]:

Date of Placement (MM/DD/YYYY)	Were You given any written information about risks, benefits, instructions for use, or warnings about Paragard before it was placed in You? (State Yes, No, or Do not recall)	Name of person who gave that information to You	What written materials were you given?
	◯ Yes ◯ No ◯ Do Not Recall		
	◯ Yes ◯ No ◯ Do Not Recall		
	◯ Yes ◯ No ◯ Do Not Recall		

b. Do You, or anyone else, including Your attorneys, still have that information?

◯ Yes ◯ No

If No, when, to the best of your recollection, was the last time You saw that information?

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

C. For each Paragard You listed in response to III(A) above, did You or anyone ***other than a Health Care Provider*** ever remove or attempt to remove the Paragard?

◯ Yes ◯ No

If Yes, provide the following information:

Date of Placement (MM/DD/YYYY)	Date You or anyone other than a HCP removed or attempt to remove the Paragard (MM/DD/YYYY)	Name of person who removed or attempted removal	Identify any problems that occurred at removal

D. For each Paragard that You have ever had removed or attempted to have removed **by a Health Care provider**, provide the following information:

Date of Removal (MM/DD/YYYY)	Name and address of HCP who removed the Paragard	Why did you have it removed?	Identify any problems that occurred at removal

E. With regard to the particular Paragard that is the subject of Your Lawsuit, did any HealthCare Provider recommend that You not have the Paragard (either in whole or in part) removed? ◯ Yes ◯ No ◯ Do not recall

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

If Yes, provide the following information:

Date of Recommendation (MM/DD/YYYY)	Name of HCP who made the recommendation	Address of HCP who made the recommendation

F. With regard to the particular Paragard (or any part of it): that is the subject of Your Lawsuit: do you know where it is?

◯ Yes ◯ No

If Yes, who has it?

◯ I have it; and it is located in (Identify City & State)

_____

◯ My lawyer has it; and it is located in (Identify City & State)

_____

◯ Someone else has it;

Identify who you believe has it: _____

Identify (City & State) where you believe it is located:

_____

G. Have You ever had any communication (written, electronic, or oral), with any of the Defendants You named in Your Lawsuit?

◯ Yes ◯ No

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

If yes, provide the following information:

Date of Communication (MM/DD/YYYY)	Method of Communication (e.g., email, letter, phone call, etc.)	Identify entity or person You communicated to or with	Brief description of the communication

IV. ALLEGED INJURIES FROM PARAGARD AND CLAIMS ASSERTED

A. Alleged Injuries

1. Are You claiming that You a suffered bodily injury, illness, or disability (referred to collectively herein as "injury") as a result of Your Paragard?

◯ Yes ◯ No

2. For each injury that You claim was caused by Your Paragard, provide the following information:

Describe separately each injury You claim	Is the injury continuing? (Yes or No)	When did You first have symptoms that You believe are related to the injury? (MM/DD/YYYY)	Name and Address of each HCP who diagnosed You with or treated you for the injury

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

3. Has any Health Care Provider informed You that any injury identified in Section IV.A.2 above was caused by, or related to, Your Paragard?

◯ Yes ◯ No

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

If **yes**, provide the following information for each injury:

Injury	Name and Address of the HCP who informed You that injury was caused by or related to Your Paragard	Date that HCP informed You that injury was caused by or related to Your Paragard (MM/DD/YYYY)

4. For each injury You claim was caused by a Paragard, have you ever had the same injury before the Paragard that is the subject of Your Lawsuit was placed in You?

◯ Yes ◯ No

If yes, provide the following information:

Injury	Date You first were aware of that injury (MM/DD/YYYY)	Name and Address of each HCP who diagnosed You with the injury	Name and Address of each HCP who treated You for the injury

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

5. Do You claim that Your Paragard worsened an injury or condition that You already have or had in the past?

◯ Yes ◯ No

If yes, identify the injury or condition that You believe was worsened as a result of Your Paragard, identify the Health Care Provider who diagnosed you with that injury, and state the date of diagnosis:

Injury or Condition	Dates of Diagnosis (MM/DD/YYYY)	Health Care Provider who diagnosed you with the injury

B. Treatment for Your Alleged Injuries

1. Did You receive any treatment for injuries or conditions You claim were caused by Your Paragard?

◯ Yes ◯ No

If yes, provide the following information in chronological order with the oldest treatment first:

Injury	Describe Treatment You Received	Date of Treatment (MM/DD/YYYY)	Name and Address of each person or HCP who treated You

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

Did You have any medical tests or procedures that You claim are related to the removal of Your Paragard?

◯ Yes ◯ No

If yes, please identify the type of medical tests or procedures:

Medical Test or Procedure	Yes/No
Ultrasound-guided removal	◯ Yes ◯ No

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

Manual vacuum aspiration	◯ Yes ◯ No
Hysteroscopy	◯ Yes ◯ No
D&C	◯ Yes ◯ No
Laparoscopy	◯ Yes ◯ No
Laparotomy	◯ Yes ◯ No
Hysterectomy	◯ Yes ◯ No
Other (Describe):	◯ Yes ◯ No

If yes, provide the following information:

Medical Test/Procedure	Date of Test or Procedure (MM/DD/YYYY)	Name and Address of each HCP who performed the test or procedure	Name and Address of each Health Care Facility where the test or procedure was performed

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

C. Claims / Damages Alleged

1. Are You making a claim for lost wages in Your Lawsuit?

◯ Yes ◯ No

a. If yes, identify every category of your lost wage claim:

☐ Salary
☐ Bonuses
☐ Stock options
☐ Retirement matching
☐ 401(k) matching
☐ Other – Please describe:

2. Are You claiming impairment of future earning capacity as a result of any injury(ies) You contend was/were caused by a Paragard?

◯ Yes ◯ No

If yes:

State the approximate total amount of future time You believe You will lose from work as a result of any injury(ies) You claim were caused by the Paragard at issue in this lawsuit:

◯ 1-7 days
◯ 8-14 days

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

- ◯ 15-30 days
- ◯ 1 - 3 months
- ◯ 3 - 6 months
- ◯ 6 months or more

3. Are You seeking to recover any "out-of-pocket" expenses (those expenses You have directly paid or incurred, including medical expenses not covered by insurance), that You claim are related to any injury(ies) You claim was/were caused by a Paragard?

◯ Yes ◯ No

If yes, what is the current amount of out – of – pocket expenses you seek to recover in this lawsuit?

- ◯ $100 or less
- ◯ $500 or less
- ◯ $501 to $1,000
- ◯ $1001 to $3,000
- ◯ $3,001 to $5,000
- ◯ $5,001 to $10,000
- ◯ $10,000 to $25,000
- ◯ more than $25,000

Are those out-of-pocket expenses continuing?

◯ Yes ◯ No

4. Has any insurer or any other entity or person paid any medical expenses related to any injury(ies) that You claim was/were caused by a Paragard and for which You seek recovery in Your Lawsuit?

◯ Yes ◯ No

5. Are You claiming emotional distress or any psychiatric injury or condition as a result of a Paragard?

◯ Yes ◯ No

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

a. If Yes, have You received any type of medical, emotional, or psychiatric care, counseling, or treatment for the emotional distress or any psychiatric injury or condition You claim?

◯ Yes ◯ No

i. If yes, provide the following information:

Injury or Condition	Dates of Treatment (MM/DD/YYYY to MM/DD/YYYY)	Name and Address of each person or HCP who treated You for the injury(ies) or condition(s)

6. Does Your spouse seek damages for loss of consortium in this Lawsuit?

◯ Yes ◯ No ◯ I do not have a spouse

If yes, Your spouse must answer the following questions and complete, sign, and provide a Declaration in the form attached to this PFS.

a. Spouse's Name: _____

b. Spouse's Date of Birth (MM/DD/YYYY): _____

c. Spouse's Social Security Number: _____

d. State whether any of the following are alleged or claimed in the Lawsuit:

Allegation or Claim	Yes/No
Loss of services of spouse	◯ Yes ◯ No

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

Impaired sexual relations	◯ Yes	◯ No
Lost wages/lost earning capacity	◯ Yes	◯ No
Lost out – of – pocket expenses	◯ Yes	◯ No
Physical injuries	◯ Yes	◯ No
Psychological injuries/emotional injuries	◯ Yes	◯ No
Other (Specify)	◯ Yes	◯ No

e. List the name, address, and specialty of any Health Care Provider from whom treatment was sought by the loss-of-consortium plaintiff for any physical, emotional, or psychological injuries or symptoms alleged to be related to his/her claim in this Lawsuit. If "none," state "none."

Name of the HCP from whom treatment was sought by the loss-of-consortium plaintiff	Address of the HCP from whom treatment was sought by the loss-of-consortium plaintiff	Specialty of the HCP from whom treatment was sought by the loss-of-consortium plaintiff

V. MEDICAL/HEALTH BACKGROUND

A. What is Your current height: _____ feet _____ inches

B. What is Your current weight: _____ lbs.

C. Identify each of Your primary care Health Care Providers for the period of five (5) years prior to Your first Paragard placement to the present time:

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

Name of HCP	Last Known Address (CITY/STATE)	Dates Seen (MM/YYYY to MM/YYYY)

D. To the extent not already provided above, identify each of Your obstetricians/gynecologists (or similar Health Care Providers) for the time period of five (5) years before placement of first Your Paragard to the present:

Name of HCP	Last Known Address (CITY/STATE)	Dates Seen (MM/YYYY to MM/YYYY)

E. To the extent not already provided above, provide the name and address of every Health Care Provider from whom You received medical advice and/or treatment from five (5) years prior to the date of placement of Your first Paragard, to the present.

Name and Address of each HCP	Specialty of the HCP	Date when advice or treatment was provided (MM/DD/YYYY)	Condition treated or consulted on

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

F. Identify each Health Care Facility where You have received inpatient or outpatient treatment for any condition, including emergency room treatment and/or surgical procedures, from the time period of five (5) years prior to placement of Your first Paragard to the present.

Name of Health Care Facility	Address of Health Care Facility (CITY/STATE)	Date of Admission or Treatment (MM/YYYY)	Reason for Admission or Treatment

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

G. For all methods of prescription birth control (other than IUDs) You have used for a period of 10 years prior to the placement of your first ParaGard, provide the following information:

Type of Birth Control	Product Name	Manufacturer Name	Dates of Use (MM/YYYY to MM/YYYY)	Name and Address of HCP who prescribed it

H. Have you ever used an IUD other than ParaGard?

◯ Yes ◯ No

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

If "yes," for each IUD you have used, please provide the following information:

Product Name	Manufacturer Name	Dates of Use (MM/YYYY to MM/YYYY)	Name and Address of HCP who prescribed it

I. Has any Health Care Provider recommended or advised that You discontinue any birth control drug or device that You have used?

◯ Yes ◯ No ◯ Do not recall

If yes, provide the following information:

Birth Control Drug or Device	Date of Recommendation (MM/YYYY)	Name and Address of HCP who made the recommendation

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

J. Prescription Medicines.

1. Identify each prescription medication You have taken on a regular basis for the time period of two years prior to the placement of your Paragard to the present time. [You do not need to list medication taken for birth control here if already identified in response to [§ G] above.]:

Name of Prescription Medication	Reason Prescribed	Dates Taken (MM/YYYY to MM/YYYY)	Name of the prescribing HCP and address (if not previously provided	Name and Address of Dispensing Pharmacy

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

K. Tobacco Use:

Check and provide information for all that apply:

◯ Never smoked cigarettes

◯ Past smoker of cigarettes

Date on which smoking ceased _____

Amount smoked on average: _____ packs per day for _____ years

◯ Current smoker of cigarettes

Amount smoked: _____ packs per day for _____ years

L. Are you making a claim for mental, emotional or psychiatric injuries, mental anguish, or depression?

◯ Yes ◯ No

If yes, have You sought or obtained emotional, psychiatric or psychological treatment of any type, including therapy, for any mental health conditions including depression, anxiety, or other emotional or psychiatric disorders during the time period of two (2) years prior to placement of Your Paragard to the present time?

◯ Yes ◯ No

If Yes, specify the condition, its date(s) of onset, and Your treating physician.

Condition	Date(s) of Onset	Treating Physician

M. For each of the following condition(s), state whether You have ever been diagnosed with the condition.

Condition	Yes/No/Do Not Recall		
High blood pressure	◯ Yes	◯ No	◯ Do Not Recall
Migraines	◯ Yes	◯ No	◯ Do Not Recall
Depression	◯ Yes	◯ No	◯ Do Not Recall
Breast Cancer	◯ Yes	◯ No	◯ Do Not Recall
Endometrial Cancer	◯ Yes	◯ No	◯ Do Not Recall

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

Ovarian Cancer	◯ Yes	◯ No	◯ Do Not Recall
Cervical Cancer	◯ Yes	◯ No	◯ Do Not Recall
Known or suspected uterine malignancy	◯ Yes	◯ No	◯ Do Not Recall
Known or suspected cervical malignancy	◯ Yes	◯ No	◯ Do Not Recall
Known or suspected breast cancer	◯ Yes	◯ No	◯ Do Not Recall
Other progesterone-sensitive cancer	◯ Yes	◯ No	◯ Do Not Recall
Acute liver disease or liver tumor (whether benign or malignant)	◯ Yes	◯ No	◯ Do Not Recall
DVT or other blood clot/blood clotting disorders	◯ Yes	◯ No	◯ Do Not Recall
Embolism	◯ Yes	◯ No	◯ Do Not Recall
Stroke	◯ Yes	◯ No	◯ Do Not Recall
Cerebral hemorrhage	◯ Yes	◯ No	◯ Do Not Recall
Aneurysm	◯ Yes	◯ No	◯ Do Not Recall
Obesity	◯ Yes	◯ No	◯ Do Not Recall
Diabetes	◯ Yes	◯ No	◯ Do Not Recall
Pelvic inflammatory disease	◯ Yes	◯ No	◯ Do Not Recall
Congenital or acquired uterine anomaly, including fibroids and/or condition that distorts the uterine cavity	◯ Yes	◯ No	◯ Do Not Recall
Uterine bleeding of unknown cause	◯ Yes	◯ No	◯ Do Not Recall
Any other condition that prevents you from using hormones. Please Describe:	◯ Yes	◯ No	◯ Do Not Recall

For each condition marked "yes" above, provide the following information:

Condition	Date of Diagnosis [MM/YYYY]	Name & Address of HCP who diagnosed You	Name & Address of each HCP who treated You

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

N. Other than the condition(s) listed above, have You ever been diagnosed with any other chronic health condition involving your reproductive organs?

◯ Yes ◯ No

If yes, provide the following information:

Chronic Health Condition	Date of Diagnosis [MM/YYYY]	Name & Address of the HCP who diagnosed You	Name & Address of each HCP who treated You)

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

O. To the best of your knowledge, do You have a family history (i.e., Parents, Siblings) of any of the following conditions, and, if so, provide the following information.

Chronic Health Condition	Parent or Sibling? [List all that apply and list the specific condition, if known.]
Cardiovascular problems	
DVT or other blood clotting disorders	
Stroke	
Embolism	
Depression	
Cancer	
Acute liver disease or liver tumor (whether benign or malignant)	

P. Are you claiming a loss of reproductive health?

◯ Yes ◯ No

Q. If yes, briefly describe the reproductive health You claim you have lost.

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

R. If You answered yes to the question in section P, above, Have You ever been treated for female infertility or consulted with any Health Care Provider related to female infertility?

◯ Yes ◯ No

If yes, identify any condition You were diagnosed with and provide the following information:

Condition/Diagnosis	Date of Diagnosis [MM/YYYY]	Name of the HCP who diagnosed You (and address if not otherwise provided)	Name of each HCP with whom You treated or consulted (and address if not otherwise provided)

S. If You answered yes to the question in section P above, is your spouse a plaintiff in your lawsuit?

◯ Yes ◯ No

If you checked the "yes" box, has Your spouse ever been treated for or consulted with any Health Care Provider related to male infertility?

◯ Yes ◯ No

If you checked the "yes" box, identify any condition Your spouse was diagnosed with and provide the following information:

Condition/Diagnosis	Date of Diagnosis [MM/YYYY]	Name & Address of the HCP who diagnosed Your spouse	Name & Address of each HCP with whom Your spouse treated or consulted

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

If Your spouse is not a plaintiff in your lawsuit, was he married to or living with you when your ParaGard was removed?

◯ Yes ◯ No

If so, did he consult with or was he treated by a Health Care Provider for male infertility from the time your Paragard was removed until the time your lawsuit was filed?

◯ Yes ◯ No

VI. SOCIAL MEDIA/INTERNET

Social Networking

A. For five (5) years prior to the placement of your ParaGard, did you read information about IUDs generally and/or Paragards in particular in a website, chat room, message board, or other electronic forum?

◯ Yes ◯ No

If yes, for each such site, provide the following information:

Name of Site	Dates Visited (MM/YYYY to MM/YYYY)

B. After the removal (and/or attempted removal) of your Paragard, did you read information about IUDs generally and/or Paragards in particular in a website, chat room, message board, or other electronic forum?

◯ Yes ◯ No

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

If yes, for each such site, provide the following information:

Name of Site	Dates Visited (MM/YYYY to MM/YYYY)

C. For five (5) years prior to the placement of your Paragard, have You ever discussed or posted about the following on any social networking site, website accounts, or message boards?

1. Your reproductive health, including, but not limited to, Your gynecologic, pelvic, or abdominal health?

◯ Yes ◯ No

2. IUDs, including, but not limited to, Paragard IUDs?

◯ Yes ◯ No

3. Your Lawsuit about Paragard or Paragard lawsuits in general?

◯ Yes ◯ No

If You answered yes to (C)(1), (2), and/or (3) above, then for each entry or post, provide the following information:

Name of Site	Date of Post (MM/DD/YYYY)	Description of substance of the entry or post

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

D. When did You first become aware of claims or lawsuits against Paragard? Please provide the month, day, and year (MM/DD/YYYY): _____.

1. How did You first become aware of the claims or lawsuits against Paragard?

a. Television advertisement

◯ Yes ◯ No

If You checked "Yes" for "Television advertisement," please describe the television advertisement.

b. Print advertisement

◯ Yes ◯ No

If You checked "Yes" for "Print advertisement," please describe the print advertisement.

c. Website or internet

◯ Yes ◯ No

If You checked "Yes" for "Website or internet," please identify what you saw or read on the site(s) You visited.

d. Other?

◯ Yes ◯ No

If You checked "Yes" for "Other," please explain and identify the source:

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

VII. WITNESSES

A. Other than Your Health Care Providers identified above, identify all persons whom You believe possess information about Your alleged injury, any facts related to Your claims, and/or Your medical condition (at any time):

Name of witness	Address	Relationship to You

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

DECLARATION

Pursuant to 28 U.S.C. § 1746, 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, information and belief formed after due diligence and reasonable inquiry.

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

_____ _____

Dated Print Name

_____

Signature

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

DECLARATION OF CONSORTIUM PLAINTIFF

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet at Sections IV.D.8 (a-e) is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry.

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

_____
Dated

_____
Print Name of Consortium Plaintiff

_____
Signature of Consortium Plaintiff

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

PRODUCTION OF DOCUMENTS AND THINGS

Attach the following documents and things to this Plaintiff Fact Sheet and Declaration in the manner set forth in the Implementing (Enabling) Order on the Plaintiff Fact Sheet (CMO No. __).

A. **AUTHORIZATIONS**: Sign and attach to this Plaintiff Fact Sheet the Authorizations for the release of records appended hereto. Check the box if You are attaching the signed Authorization.

- ☐ A-1 Authorization for Release of Medical Records is signed and attached
- ☐ A-2 Authorization for Release of Psychological/Psychiatric Records is attached (if claiming emotional distress, menta, emotional, psychological or psychiatric injury)
- ☐ A-3 Authorization to Release Employment Information is attached (if claiming lost wages, lost earnings or impairment of earning capacity)
- ☐ A-4 Authorization for Release of Tax Records (if claiming lost wages, lost earnings or impairment of earning capacity)
- ☐ A-5 Authorization for Release of Insurance Records
- ☐ A-6 Authorization for Release of Medicare Records
- ☐ A-7 Authorization for Release of Worker's Compensation Records (if applicable)
- ☐ A-8 Authorization for Release of Disability Claims Records (if applicable)

B. If You are completing this PFS on behalf of a deceased person, please attach (1) the legal documentation establishing that You are the legal representative of the estate and (2) a copy of the decedent's death certificate.

DOCUMENT REQUESTS:

"Document" as used below means hard copy documents and electronically-stored information (ESI), as defined in the Case Management Order Regarding Production of Electronically Stored Information and Paper Documents ("ESI Protocol") (Doc. No. 128).

Communications solely with Your attorneys, and that You did not show or give to anyone else, are not included in these Requests.

For each response below, state whether You have any of the following documents in You possession, custody, or control, by checking the appropriate box below each Request.

If You have documents in Your possession, custody, or control, provide a true and correct copy of such documents with this completed Plaintiff Fact Sheet.

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

1. Produce all medical and pharmacy records (for example, receipts, prescriptions, and records of purchase) You have in Your possession, custody, or control describing, discussing, or referring to Paragard including the following records:

    a. Patient information sheets, "Information for Patients," "Prescribing Information," package inserts, brochures, handouts, pamphlets, consent forms, or product literature for a Paragard;

    b. Procedures, tests, or Health Care Provider office visits You had to place a Paragard including consent forms, appointment cards, and all product identification;

    c. Any follow-up care You received following the placement of Your Paragard;

    d. Any procedure, test, Health Care Facility in-patient or out-patient admission, or Health Care Provider office visit You had to remove a Paragard;

    e. Any follow-up care You received following the removal of Your Paragard; and

    f. All pharmacy records for any prescription medication that You took for any injury You claim was caused by Your Paragard.

    ◯ The documents are attached.

    ◯ I have no documents.

2. Produce all medical and pharmacy records that were requested or obtained for Your Lawsuit, unless already produced in response to Request number 1;

    ◯ The documents are produced in response to Request number 1.

    ◯ The documents are attached.

    ◯ I have no documents.

3. Produce all documents in Your possession, custody, or control about Paragard including the following:

    a. Documents You created describing, discussing, or referring to Paragard or any of the physical or mental conditions You are claiming are related to Your Paragard;

    b. All letters, e-mail, or other electronic messages You have written to any Defendant, Health Care Providers, or governmental entities about Paragard;

    c. All news articles or medical literature that describe, discuss, or reference Paragard, or any of the Defendants You name in Your Lawsuit;

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

d. All advertisements or promotional material for Paragard You saw before Your Paragard was placed in You;

e. All attorney advertisements for potential claims or lawsuits directed to Paragard You saw before Your Lawsuit was filed;

f. All information that describes, discusses, or refers to Paragard that You downloaded or printed from the internet before Your Lawsuit was filed;

g. Any recorded statement or written statement or notes of any statement from any of the Defendants in Your Lawsuit and/or any of their agents, representatives, or employees about Paragard and/or the injuries or claims alleged in Your Lawsuit;

h. All social media or internet posts You made or posts made about You in which you were tagged or of which You are aware that describe, discuss, or refer to Paragard;

i. All social media or internet posts You made or posts that were made about You, that describe, discuss, or refer to any of the alleged injuries, conditions, or damages You claim in Your Lawsuit;

j. All calendars, journals, diaries, and notes that describe, discuss, or refer to Paragard or the injuries, damages or treatment You are alleging in Your Lawsuit;

k. All statements obtained from or given by any person, other than Your attorney(s) or expert(s), having knowledge of the facts relevant to the subject of Your Lawsuit; and

l. Any photographs or videos that depict the Paragard placed in You or its removal, the injuries You allege were caused by Paragard, or any care and/or treatment You received

◯ The documents are attached.

◯ I have no documents.

4. Produce all documents in Your possession, custody, or control describing, discussing, or that refer to the following:

a. IUDs of any type in general or any alleged health risks related to IUDs in general; and/or

b. Birth control or contraception in general or any alleged health risks related to birth control or contraception in general.

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

- ◯ The documents are produced in response to one or more other Requests for Production above.
- ◯ The documents are attached.
- ◯ I have no documents.

5. Produce all documents describing, discussing, or that refer to the following, as identified in Your responses in Your Plaintiff Fact Sheet:

   a. Any workers' compensation claims as identified in Your response to § II.Q.2 (workers' compensation claims);

   b. Any Social Security or state/federal disability claims as identified in Your response to § II. Q.3 (Social Security or state/federal disability claims);

   c. Any lawsuits or claims as identified in Your response to § II. R (lawsuits or claims);

   d. Any agreements identified in Your response to § II. S. (Agreements with respect to your lawsuit);

   e. Any written information identified in Your response to § III.B.2 (written information);

   f. Any actions or steps taken to preserve or maintain the Paragard removed from You; (Response to § III. F);

   g. The location(s) of the Paragard or any of its pieces removed from You, or any transfer of them, including all chain of custody documents. (Response to § III. F);

   h. Any communication or correspondence with Defendants as identified in Your response to § III. G. (Communications between You or anyone acting on Your behalf, and any Defendant you have named in the lawsuit); and

   i. Any out-of-pocket expenses as identified in Your response to § IV. C.3 (out-of-pocket expenses).

   - ◯ The documents are attached.
   - ◯ I have no documents.

6. **If You are claiming lost wages, loss of earnings, or lost earnings capacity**, produce Your W-2s and all tax records reflecting Your income for the five (5) years preceding the removal of Your Paragard that is the subject of Your Lawsuit to the present.

   - ◯ I am not claiming lost wages, loss of earnings, or lost earnings capacity.

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

- ◯ The documents are attached.
- ◯ I have no documents.

7. **If You are suing on behalf of another individual**, produce copies of the death certificate, letters testamentary, letters of administration, powers of attorney, guardianship, or guardian ad litem orders or other documents relating to Your status as a plaintiff in Your Lawsuit.

   - ◯ I am not suing on behalf of another individual.
   - ◯ The documents are attached.
   - ◯ I have no documents.

8. **If Your spouse is bringing a loss of consortium claim,** produce all documents constituting, evidencing, or otherwise relating to Your spouse's claims or damages for loss of consortium.

   - ◯ There is no loss of consortium claim asserted
   - ◯ The documents are attached.
   - ◯ I have no documents.

9. To the extent not already produced in response to a Request for Production above, produce the medical records of each and every Health Care Facility, pharmacy, or Health Care Provider identified by You in response to the questions in Sections III, IV, and V. E. of the Plaintiff Fact Sheet (Your medical care and history for the time period beginning five (5) years prior to the placement of Your first Paragard and continuing to the present).

   - ◯ The documents are produced in response to one or more other Requests for Production above.
   - ◯ The documents are attached.
   - ◯ I have no documents.

10. Produce all test protocols, test results, or reports of testing or test results on the Paragard, including any and all pieces of the Paragard that is the subject of Your Lawsuit.

    - ◯ The documents are attached.
    - ◯ I have no documents.

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

Exhibit A-1

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Patient Name: _____

Date of Birth: _____

Social Security Number: xxx-xx-

I hereby authorize: [Name of Physician, Healthcare Provider, or Facility]

to release all existing medical records and information, regarding the above-named person's medical care, treatment, physical condition(s) and/or medical expenses revealed by observation or treatment past, present and future to the below recipient(s):

Ontellus
910 Louisiana, Suite 4500
Houston, TX 77002

These records shall be used solely in connection with the currently pending litigation involving the person named above:

In Re: ParaGard IUD Products Liability Litigation
In the United States District Court for the Northern District of Georgia, Atlanta Division
Case No. 1:20-md-02974

This authorization shall cease to be effective as of the date on which that litigation concludes.

INFORMATION TO BE RELEASED OR INSPECTED:

__X__ Entire Chart/record, including, but not limited to, all of the following:

✓ Immunizations **✓ Discharge Summary** **✓ History & Physical** **✓ Consultations** **✓ Operative Reports** **✓ Emergency Room Reports** **✓ Pharmacy/prescription records** **✓ Emergency transport reports**	**✓ X-ray and other radiologic reports/films/images** **✓ Laboratory reports** **✓ EEGs, ECGs or other electronic tests** **✓ Nursing notes** **✓ Doctor's Orders & Progress Notes** **✓ Copies of Reports Originating from other Providers**	**✓ PT, OT and/or Speech Therapy Notes** **✓ Rehab Clinic Reports** **✓ Occupational Health Clinic Records** **✓ Worker's Compensation** **✓ Billing and Patient Accounts records** **✓ Social Services reports and/or evaluations**
☐ Other: _____		

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and sexually transmitted disease.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation, and that such re-disclosure by the recipient will make this information no longer protected by the federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of the firm(s) listed above.

Dated this _____ day of _____, _____

_____

[Plaintiff Name]

Exhibit A-2

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL/PSYCHIATRIC RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Patient Name: _____

Date of Birth: _____

Social Security Number: xxx-xx-_____

I hereby authorize: [Name of Physician, Healthcare Provider, or Facility]

to release all existing records and information regarding the above-named person's psychological or psychiatric care, treatment, condition(s) and/or expenses revealed by observation or treatment past, present and future to the below recipient(s):

Ontellus 910 Louisiana, Suite 4500 Houston, TX 77002

These records shall be used solely in connection with the currently pending litigation involving the person named above:

In Re: ParaGard IUD Products Liability Litigation
In the United States District Court for the Northern District of Georgia, Atlanta Division
Case No. 1:20-md-02974

This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that this authorization includes information regarding the diagnosis and treatment of psychiatric and psychological disorders, and that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation, and that such re-disclosure by the recipient will make this information no longer protected by the federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of the firm(s) listed above.

Dated this _____ day of _____, 2015

_____
[Plaintiff Name]

Exhibit A-3

AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

To: [Name of Employer]

This will authorize you to permit **Ontellus, 910 Louisiana, Suite 4500, Houston, TX 77002**, to inspect and copy, or be furnished with, copies of all applications for employment, resumes, records of all positions held, job descriptions of positions held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, nurse, psychiatric and dental records; x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which [Name of Employee/Plaintiff]**,** was involved including correspondence, reports, claim forms, questionnaires, records of payments made to him or on her behalf; and any other records relating to [Name of Employee/Plaintiff] employment.

A photocopy of this authorization shall have the same force and effect as an original authorization executed by me. This authorization shall remain in full force and effect until you have been advised by me, in writing that it is no longer to be effective.

_____ _____

Date [Name of Employee/Plaintiff]

DOB: _____

SSN: _____

Exhibit A-4

Form **4506**

(Novmeber 2021)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Ontellus 910 Louisiana, Suite 4500, Houston, TX 77002

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ 43.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) | Date

▶ Print/Type name | **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** | Date

▶ Print/Type name

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B, Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

Exhibit A-5

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: [Name of Insurance Company]

This will authorize you to permit **Ontellus, 910 Louisiana, Suite 4500, Houston, TX 77002**, to inspect and copy, or be furnished with, copies of all insurance records of any sort, including but not limited to, statements, applications, explanation of benefits, disclosures, correspondence, notes, settlements, agreements, contracts, or other documents, concerning [Name of Insured/Plaintiff].

A photocopy of this authorization shall have the same force and effect as an original authorization executed by me. This authorization shall remain in full force and effect until you have been advised by me, in writing, that it is no longer to be effective.

_____ _____

Date [Name of Insured/Plaintiff]

DOB: _____

SSN: xxx-xx-_____

Exhibit A-6

Medicare

Beneficiary Services:1-800-MEDICARE (1-800-633-4227)
TTY/TDD:1-877-486-2048

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

For faster processing, you may complete your Authorization form online by logging into www.MyMedicare.gov with valid credentials where Authorized Representatives can be added or updated under 'My Accounts'.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.** You may also check any of the remaining boxes and include any additional limitations in the space provided. For example, you could write "payment information".

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Instructions for Completing Section 2C of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, check the box: "All information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, check the box "Exclude information about alcohol and drug abuse, mental health treatment, and HIV". Then proceed with the rest of the form.

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

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

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

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

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

1. Print the name of the person with Medicare.

Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters.

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

2. This section tells Medicare what personal health information to give out. Please check a box in 2A to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2B that apply to the type of information you want Medicare to give out. Box 2C must be completed by **New York Residents**.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. This section tells Medicare the reason for disclosure.

5. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization.

If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

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

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

7. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

8. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

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

1. **Print Name** (First and last name of the person with Medicare)	**Medicare Number** (Exactly as shown on the Medicare Card)	**Date of Birth** (mm/dd/yyyy)

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

2A: Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:

- ☐ Limited Information (go to question 2b)
- ☐ Any Information (go to question 3)

2B: Complete <u>only</u> if you selected "limited information". Check all that apply:

- ☐ Information about your Medicare eligibility
- ☐ Information about your Medicare claims
- ☐ Information about plan enrollment (e.g. drug or MA Plan)
- ☐ Information about premium payments
- ☐ Other Specific Information (please write below; for example, payment information)

_____

_____

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

- ☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

3. **Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely

☐ Disclose my personal health information for a specified period only

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

4. **Fill in the reason for the disclosure (you may write "at my request"):**

_____

_____

5. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

Name **Ontellus**

Address **910 Louisiana, Suite 4500 Houston, TX 77002**

Name _____

Address _____

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke authorization, send a written request to the address noted below. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

6. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

Signature _____ Telephone Number _____ Date (mm/dd/yyyy) _____

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

_____

_____

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

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

_____

_____

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

7. **Send the completed, signed authorization to**:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Print Form

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

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

AUTHORIZATION TO DISCLOSE MEDICAID INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm of Ulmer & Berne, LLP, Greenberg Traurig, LLP, and/or to Ontellus at 910 Louisiana, Suite 4500 Houston, TX 77002, any and all records, since **[DATE],** containing Medicaid information, including those that may contain protected health information (PHI) regarding **[PATIENT NAME],** including records created after the date of signature. This authorization should also be construed to permit agents or designees of Ulmer & Berne, LLP, Greenberg Traurig, LLP, and/or Ontellus to copy, inspect and review any and all such records. 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 [**PATIENT NAME];** 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.

These records shall be used solely in connection with the currently pending litigation involving the person named above:

> *In Re: ParaGard IUD Products Liability Litigation*
> In the United States District Court for the Northern District of Georgia, Atlanta Division
> Case No. 1:20-md-02974

Unless revoked in writing, this authorization shall cease to be effective as of the date on which that litigation concludes. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and sexually transmitted disease.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage.

I understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization.

I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation, and, in such case, the disclosed PHI will no longer be protected by Health Insurance Portability and Accountability Act (HIPAA) 45 CFR Section 164, Subpart E.

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Ulmer & Berne, LLP, Greenberg Traurig, LLP, and/or to Ontellus.

Signature of Patient or Legal Representative	Patient's Name
Name of Patient or Legal Representative	Patient's Former/Alias Name
Date	Patient's Date of Birth
Relationship to Patient	Patient's Social Security Number

State of California
Health and Human Services Agency Department of Health Care Services

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to inspect your protected health information in records, which Medi-Cal creates or maintains. You also have the right to request copies of those records. You will receive a response to your request within 30 days after we receive your request. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. **Mail this completed form to address below:**

Department of Health Care Services
DHCS/MEDI-CAL FI
P.O. Box 526018
Sacramento, CA 95852-6018
(916) 636-1980

Directions

Please read the following before completing this form. If any of the circumstances below applies to you, you may not need to fill out this form.

You have a personal injury case and Medi-Cal has paid for services related to the injury and you want information about these services and/or payments.

Or

You are requesting access to records on behalf of a deceased Medi-Cal beneficiary in order to repay Medi-Cal for services received by the deceased beneficiary. You may have received an Estate Recovery Questionnaire in the mail.

Or

You are involved in a worker's compensation case in which Medi-Cal has paid for services for the injury you received while on the job.

Please call (916) 650-0490 for further information about these circumstances.

If none of these circumstances apply, please complete the form.

State of California
Health and Human Services Agency Department of Health Care Services

Your Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	

Description of the Specific Information to be Released/Inspected

Check each type of confidential information you authorize to be released/inspected:	
☐ HIV or AIDS	☐ Alcohol/Drug Information
☐ Mental Health/Behavioral	☐ Health Genetic Testing
Other:	
Information from the categories above will be authorized for the following period of time: from_____ (date) to_____ (date).	

State of California
Health and Human Services Agency Department of Health Care Services

Check Each Type of Protected Information You Want to Access:	
☐ **Claim Detail Reports**, which contain claims paid by Medi-Cal for services received.	**Managed Care Records:** ☐ Enrollment Records ☐ Disenrollment Records ☐ Capitation Paid to Health Plan ☐ MERS Fair Hearing Documentation
☐ **Treatment/Service Authorization Request Screens**. Printouts contain patient names, which providers have requested services, which services were requested, the decision about the service(s), including a simple description of the decision, and whether the provider has billed for these services.	**Denti-Cal Records:** Call (800) 322-6384
	☐ **Genetically Handicapped Persons Program (GHPP) and/or California Children's Services (CCS) Records.**
☐ **Case Management Records**, which contain case manager notes.	*Please contact your care provider or managed care plan if you want access to your medical records.*

I am requesting copies of records for the following dates of service:

You must specify dates of service in order to get records.

From Date (month/day/year) _____

To Date (month/day/year) _____

State of California
Health and Human Services Agency Department of Health Care Services

Please note: A request for records of services provided up to six years ago is a 30-day process. All other requests have an approximate 60-day time frame for additional processing.

☐ Please mail me a copy of the requested information.

☐ I wish to review the requested information in person.

If you request to review records in person, you will be contacted to schedule an appointment.
Location available for in person review: **Sacramento Only**

Requestor's Identifying Information:

☐ Address verification attached

Type: _____ (Utility Bill, Phone Bill, Driver's License, Etc.)

☐ Copy of identification attached

Type: _____ (CA Driver's License, CA DMV Identification Card, Birth Certificate, Benefits Identification Card, Managed Care Card, State Or Federal Employee ID Card)

Number: _____

(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED)

Notarized By _____ On _____ (Date).

Notary Public Number:_____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

This authorization for release of the above information to the above named persons or organizations will expire on: _____ (date).

I understand that by signing this authorization:

- I authorize the use and/or disclosure of my individually identifiable health information at the request of the patient (myself). I understand that this authorization is voluntary.
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization.
- Health Information disclosed through the authorization may be subject to disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.
- I have the right to receive a copy of this authorization.
- Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Member Signature:	Date:

Authorization for the Use and Disclosure of Protected Health Information

Information Identifying the Individual Whose Records Are Being Requested

Name of Individual: _____ SSN: _____

Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration (AHCA or Agency) may request your Social Security Number pursuant to Section 119.071, Florida Statutes. If provided, the Agency will use your information for purposes of finding the requested information.

Individual's Street Address: _____

City: _____ State: _____ Zip Code: _____

Medicaid ID or Gold Card Number: _____

Phone Number: _____ Date of Birth: _____

Provide the *specific* dates of service included. From: _____ To: _____

Purpose for this disclosure: _____

Date I wish this authorization to expire (expires in one year if no date is provided): _____

☐ **I direct AHCA to mail the requested hard copy records to the below person(s), group or entity:**

Documents Requested: ☐ Paid Claims Records ☐ Denied Claims Records ☐ All Claims Records

☐ Other: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I authorize the below person(s), group or entity to verbally discuss specific topics with AHCA:**

The *specific* topics to be discussed are: _____

Name: _____

I understand the following: I have the right to revoke this authorization at any time by writing to the Agency's Privacy Officer or completing the revocation section on the second page of this form and sending it to the address listed for the Agency's Privacy Officer. I understand that any information previously disclosed would not be subject to my revocation request. The information described above may be re-disclosed by the person or group that I am giving the Agency permission to disclose to and therefore my information may no longer be protected by Federal privacy regulations. I may inspect or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure. I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.

This form specifically includes authorization to provide documents related to sensitive health conditions including: drug, alcohol or substance abuse, psychological or psychiatric treatment, sickle cell anemia, birth control or family planning, genetic diseases or tests, tuberculosis, and HIV/AIDS or STDs. **To restrict sensitive information, see Page 2.**

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Signature: _____ Date: _____

Printed Name: _____

Legal Authority (If Other Than Individual): _____

If you are a legal representative of the person whose information you are requesting disclosure of, you must provide documentation proving your legal authority to request this information (for example, power of attorney, guardianship papers, health care surrogate form, Custody Order, Order Appointing Personal Representative, Letters of Administration).

Authorization for the Use and Disclosure of Protected Health Information

Instructions for Completing this Form

1. Complete the first page of this form and return it to: **HIPAA Privacy Officer, Agency for Health Care Administration, 2727 Mahan Dr., MS #4, Tallahassee, FL 32308, Phone: 850-412-3960, Fax 850-414-6837 Email: HIPAAComplianceOffice@AHCA.MyFlorida.com**.

2. Special types of health information have specific laws and rules that must be followed before that information may be disclosed:

HIV/AIDS and Sexually Transmitted Diseases (STD): All information about HIV/AIDS and sexually transmitted diseases is protected under Federal and State laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV/AIDS or STD information, this authorization must include a statement of the specific HIV/AIDS or STD information you are giving the Agency permission to disclose. Re-disclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission. **To NOT INCLUDE this information, initial here _____**

Alcohol or Drug Treatment: Alcohol and/or drug treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in Federal and State laws or regulations. To release alcohol and/or drug treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Re-disclosure of your alcohol and/or drug treatment records is not allowed except in compliance with law or with your written permission (see 45 CFR Part 2). **To NOT INCLUDE this information, initial here _____**

Mental Health Treatment: Mental health treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization unless otherwise allowed in Federal or State laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Disclosure of your psychotherapist's notes needs separate written permission. Re-disclosure of your mental health treatment records is not allowed except in compliance with law or with your written permission. **To NOT INCLUDE this information, initial here _____**

Revocation of Authorization

DO NOT COMPLETE FOR A NEW AUTHORIZATION. THIS SECTION IS ONLY FOR REVOKING A PREVIOUS AUTHORIZATION. Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes.

Name		Date of Birth			
Phone		Social Security Number			
Medicaid ID Number or Gold Card Number					
Street Address					
City		State		Zip Code	

I hereby revoke my authorization for the Agency for Health Care Administration to disclose my protected health information to the following person(s), group or entity:

Signature		Date	
Printed Name		Legal Relationship to Individual	

If you are the subject's legal representative, you must provide documentation proving your legal authority to revoke this authorization. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).

SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Section A: Participant Information

Instructions: Read and complete the section below. Print clearly.

I understand that my Protected Health Information[1] (or if Personal representative, the Protected Health Information of the Participant) will be released by the State Health Benefit Plan ("SHBP") to the individual(s) in Section C.

Participant Name: _____

Address: _____

Telephone Number: _____ Date of Birth: _____

Identification (ID) Number (from ID card): _____

Second ID Number (if covered under multiple SHBP coverage options): _____

If you are the Personal Representative requesting the information of a Participant, please complete the section below:

Personal Representative Name: _____

Relationship to Participant: _____

Address: _____

Telephone Number: _____ Last Four Digits of SS#: _____

Section B: Protected Health Information To Be Disclosed

Instructions: Read and complete the section below. Print clearly.

Describe the specific health information you are requesting SHBP to disclose (include dates of service, provider name, claim number or other information, as applicable):

_____

_____

Describe the purpose of the information you are requesting SHBP to disclose (if more than one purpose, list each one):

_____

_____

[1] Protected Health Information is defined as any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. 45 C.F.R. § 160.103.

Section C: Person(s) Authorized to Receive Protected Health Information

Instructions: Read and complete the section below. Print clearly.

Recipient Name/Title: _____

Company: _____

Address: _____

Telephone Number: _____

Section D: Expiration and Revocation

Instructions: Read and complete the section below. Print clearly.

This authorization will expire (complete only one):

On _____ / _____ / _____
(mm) (dd) (yyyy)

OR

On the occurrence of the event described below, that must relate to the participant or to the purpose of the use and/or disclosure being authorized (for example, upon the termination of coverage under SHBP).
Describe event: _____

Section E: Required Notices

Right to Revoke

You have the right to revoke this authorization at any time, except to the extent that SHBP has acted in reliance upon this authorization, provided that you notify SHBP in writing at the address below:

State Health Benefit Plan
Attention: Dianne Patterson
Post Office Box 1990
Atlanta, GA 30301

-OR-

shbp.eligibility@dch.ga.gov

-OR-

FAX: 1-866-828-4796

Information Subject to Redisclosure

Information disclosed pursuant to this authorization may be subject to redisclosure by the Recipient authorized under Section C, and therefore, will no longer be protected under the HIPAA Privacy Rule.

No Conditions on Treatment, Payment, Enrollment or Eligibility

SHBP does not condition treatment, payment, enrollment or eligibility for benefits on whether the Participant or Personal Representative signs an authorization.

Notice of Privacy Practices

You may view a copy of our Notice of Privacy Practices on the Department of Community Health's website: http://dch.georgia.gov/shbp-legal-notices

Section F: Authorization and Signature

Instructions: Read and complete the section below. Sign and date.

I understand that it is the policy of SHBP not to release such information except for the purpose of treatment, payment, or healthcare operations.

By signing below, I authorize SHBP to discuss and/or disclose my Protected Health Information for the purpose(s) described above to the individual(s) designated in Section C.

If you are the Personal Representative of the Participant, by signing below, you authorize SHBP to discuss and/or disclose the Protected Health Information of the Participant for the purpose(s) described above to the individual(s) designated in Section C.

Signature of Patient or Personal Representative **Date:**

Return the completed Authorization to Release Protected Health Information Form to:

State Health Benefit Plan
Attention: Dianne Patterson
Post Office Box 1990
Atlanta, GA 30301
-OR-

shbp.eligibility@dch.ga.gov

-OR-

FAX: 1-866-828-4796

If you are a Personal Representative requesting the release of Protected Health Information on behalf of a Plan Participant, you must provide documentation sufficient to establish your authority to act on behalf of the person you are representing.

Failure to provide all necessary information will result in a denial of your authorization request.

State of Illinois
Department of Human Services

Authorization to Disclose/Obtain Information

(1) I authorize _____ to ☐ disclose ☐ obtain ☐ disclose and obtain
(Hospital/Agency/Individual)

(2) ☐ Discharge Summary ☐ Discharge Staffing ☐ Psychiatric Evaluation ☐ Social History ☐ History and Physical
☐ Treatment/Hab Plans ☐ Assessments (Specify Type) _____ ☐ Physicians Orders
☐ Med. Administration Records ☐ Progress Notes ☐ Behavioral Plans ☐ Consultations ☐ Lab/X-Ray
☐ Photos ☐ Record Abstract ☐ Patient Review ☐ Other (specify) _____

Concerning the care of the below named person from DATE (or RANGE OF DATES): _____

(3) About (Name) _____ Social Security Number: _____
Date of Birth: _____ Alias: _____

(4) For purposes of: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Financial/Benefits
☐ Attorney ☐ State Law/Court ☐ Death ☐ Other (specify) _____

(5) Information may be disclosed/obtained: Mail, In-Person, Phone, E-Mail or by Fax (For Urgent/Emergency Needs).
Restrictions if any: _____

(6) ☐ Disclose To	☐ Obtain From
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:

(7) This authorization is valid until calendar date: _____ Month _____ Day _____ Year

(8) It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs. **CHECK BELOW FOR EXCLUSION ONLY.**
☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Developmental Disabilities
☐ HIV/AID's ☐ Other (specify) _____

(9) I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/ plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

(10) I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

(11) Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

(12) _____ _____
Signature of individual (age 12 or older) Date/Time

(13) _____ _____
Signature of parent/guardian (Under 18 or Disabled) Date/Time

(14) _____ _____
Witness OR (2nd parent/guardian, if co-custodial, may sign here) Date/Time

(15) _____ _____
Signature of staff person disclosing/obtaining information Date/Time:

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System.
A facsimile of this original shall have the same force and effect as the original.

The Standards for Privacy of Personally identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987; 52 FR4 1997, November 2, 1987)

NOTE: Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment, payment, or enrollment in a health plan or eligibility for benefits

State of Illinois
Department of Human Services

Authorization to Disclose/Obtain Information

INSTRUCTIONS: Authorizations to Disclose/Obtain Information

(1) Identify whether the form will be used to disclose, to obtain or to disclose/obtain (share) information and whom you are authorizing to perform this function.

(2) Check the specific information you wish to disclose/obtain. Check only what is the minimum necessary to fulfill the purpose of disclosure. Enter a service date - if unknown, indicate "last service date" and only checked information from last service dates will be released or obtained.

(3) Complete the individual's name, date of birth, social security number and aliases or a maiden name to help correctly identify the individual.

(4) Check the purpose or reason why the information needs to be disclosed/obtained.

(5) Circle all manners which the information may be disclosed/obtained. If you wish to restrict any of these, please specify. If nothing is specified, all manners of release will be considered authorized. (Information will only be faxed if URGENT.)

(6) Complete the name and address of the agency, facility or person to whom you will disclose the information or complete the name and address of the agency, facility or person from whom you are obtaining the information. If you wish it to be phoned or faxed, include area code and numbers.

(7) Complete the calendar date (month, day and year) on which this authorization will expire. Information cannot be disclosed/obtained without a specific date of expiration.

(8) Sensitive information will be released/obtained unless you specifically check an exclusion. **If no items are checked all information within the patient record is subject to disclosure.**

(9) Self-explanatory.

(10) Self-explanatory.

(11) Self-explanatory.

NOTE: In accordance with federal and state privacy laws only the following persons shall be entitled to consent in writing to the inspection, copying and/or the release of the individual's protected health information.

- The individual if they are 12 years of age or older.
- The parent or guardian of an individual less than 12 years of age **(If both parents have co-custody, both individuals must sign - one on line 13, the other on line 14.)**
- The parent or guardian of an individual between the ages of 12 and 17, provided the individual does not object and has signed the authorization.
- The guardian of a person 18 years of age or older.
- An attorney or guardian ad litem who represents a minor 12 or older provided the court has entered an order granting this right.

(12) Individual to sign and date here if - age 12 or older.

(13) Parent to sign and date here if -

- Individual is less than 12 years of age or
- If individual is between 12 and 18 and has signed on line 12 or Guardian to sign here if -
- If individual is 18 years of age or older but is legally disabled. **You must provide a copy of the Guardianship court order granting you this right.**

Guardian to sign here if -

- If you are a guardian ad litem or attorney representing a minor 12 or older in any judicial or administrative proceeding. **You must provide a copy of the court order granting you this right.**

(14) Witness to sign and date here. **All authorizations require a witness signature to attest to the identity of the person entitled to give consent** (person signing line 12/13)
Line may be used by a co-custodial parent.

(15) Staff person disclosing/obtaining information signs here. Specific dates when disclosed/obtained shall be documented in the individual's clinical record and/or the Disclosure Tracking system.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL AND HEALTH INFORMATION - DFR

State Form 54621 (2-11)

FAMILY AND SOCIAL SERVICES ADMINISTRATION / DIVISION OF FAMILY RESOURCES

Purpose

For you to authorize the disclosure of your personal information, which may include health information, to persons or organizations outside of the Division of Family Resources (DFR). Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.

Your Name and Identification Information

Name_____

Address_____

City_____ State_____ ZIP Code_____

Telephone (_____)_____ E-mail Address_____

Date of Birth_____ Last 4 Digits of Social Security #_____

What personal information, including health information, are we to disclose?

Please describe the type of information we are allowed to disclose; for example, your contact information, your benefits status, your current eligibility status and/or historical status, or "as requested by the authorized person/organization."[1]

What is the purpose of the requested disclosure of your personal information?

Please describe the purpose for the disclosure (e.g., assistance with obtaining or using FSSA benefits/services, legal assistance, the person is involved in my use of FSSA benefits/services, or simply "at my request").

To whom are we authorized to disclose your personal information?

Please state the names of the individuals or organizations, including contact information.

[1] *If the personal information to be disclosed is identified "as requested by the authorized person/organization", then we will rely on them to identify what information is to be disclosed when receiving their request for disclosure; we will also rely on them to specify the minimum amount of personal information, including health information, that is reasonably necessary to accomplish the purpose of the request.*

Which DFR program areas are you authorizing to disclose your personal information?

❑Medicaid Eligibility ❑Supplemental Nutrition Assistance Program (SNAP)/Food Stamps ❑Child Care Assistance

❑Temporary Assistance for Needy Families (TANF) ❑Other_____

Expiration Date or Event

This authorization will automatically expire sixty (60) calendar days from the date you sign it. You may specify an earlier or later expiration date, or you may specify an event upon which this authorization will expire (e.g., "when my concern has been addressed"). Please select one of the following three:

❑Allow to automatically expire in sixty (60) calendar days ❑Expire on this date (month, day and year): _____

❑Expire on this event: _____

Right to Revoke

You have the right to revoke this authorization at any time. You may revoke this authorization by giving written notice, including e-mail notice, to the DFR contact below. Any disclosures of your personal information, including health information, which we may have made under this authorization prior to revocation will not be affected (they were made while this authorization was still in effect).

Further Disclosure

Once we disclose your personal information, including health information, to the above persons/organizations, the information may no longer be protected under state or federal privacy laws. We cannot control what these persons/organizations do with your information.

Signature

Having had full opportunity to read and consider the contents of this authorization, including my rights and the risks of further disclosure as described above, I am authorizing DFR to disclose my personal information, including health information, to the persons or organizations I have identified above. I understand DFR will disclose only that information which is necessary to accomplish the stated purpose of the disclosure. The information disclosed will be limited to the minimum necessary. I also understand that I am under no obligation to sign this authorization. I also understand that the services and benefits provided to me by or through DFR will not be affected whether or not I sign this form.

Signature_____ Date_____

If this authorization is signed by an individual's personal representative on behalf of the individual, please complete the following:

Personal Representative's Name_____

Contact Information *(include telephone no.)*_____

Relationship to the Individual_____

It is the policy of DFR to verify that an individual's authorized representative is identified as such in our files prior to acting on this authorization.

You will be provided with a copy of this authorization after you sign it.

Contact Information

To revoke this authorization prior to the expiration date or event, contact:

The Division of Family Resources
Attention: Constituent Care Services
402 W. Washington, Room W-392, Indianapolis, IN 46204-2739
E-mail: cc@fssa.in.gov

Iowa Department of Human Services

AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION

Client Name:	ID#:	SS#:
Date of Birth:	Parent/Guardian:	

I authorize the following individual or agency to share written and oral information (*two-way or reciprocal release*) about my needs and the services I receive . . .

Name or agency to release and receive information:	
Address:	
City/State/Zip:	
Phone:	Fax:

With the following individual or agency:

Name or agency to receive and release information:	
Address:	
City/State/Zip:	
Phone:	Fax:

***The information released or shared may include*:**

☐ Face sheet ☐ Admission status ☐ Psychological reports
☐ Discharge summary ☐ Family data photos ☐ Social history ☐ Lab results ☐ Treatment and aftercare plans
☐ Diagnosis/allergies ☐ X-ray/imaging reports ☐ Team notes ☐ Medication history ☐ History & physical exam
☐ Initial assessment ☐ Immunization record ☐ School records ☐ Court documents ☐ Evaluation & recommendations
☐ Receiving phone calls
☐ Consultation reports from (doctor/specialty name): _____
☐ Other (please specify): _____

Other (note exceptions or limits to this release):

This information is being used ONLY for (state purpose):

SPECIFIC AUTHORIZATION FOR RELEASE **I authorize the release of the information listed at the right, which requires specific consent under federal law:**	**Type of Information**	**Authorizing Initials**
	Mental health evaluation/treatment*	
	AIDS/HIV-related	
	Substance abuse**	

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time by completing form 470-3949, Request to Revoke an Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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 shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. If I have questions about disclosure of my health information, I can contact (name) _____ at (phone) _____. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing signature:	Date:	Expiration date:
Relationship to client: ☐ Self ☐ Legal representative ☐ Nearest living relative ☐ Other (specify below)		
☐ Not Required	Witness signature:	
☐ Required	Witness signature:	

A photocopy of this signed authorization shall have the same force and effect as this original.

RECORD OF DISCLOSURES

(Required for mental health information)

	Date	Name of Recipient	Contents Disclosed	Sent By
1.				
2.				
3.				
4.				
5.				

* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.

** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

Notice to Recipients of Mental Health Information

In accordance with "Disclosure of Mental Health and Psychological Information" (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of Substance Abuse Information

This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of HIV-Related Testing Information

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

For assistance or consultation you may contact the IDHS Diversity Program Unit. Complaints should be filed promptly, but in most instances, no later than 180 days of the alleged discriminatory act. If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

CHFS-305
922 KAR 1:510
(R. 11/2021)

CABINET FOR HEALTH AND FAMILY SERVICES
COMMONWEALTH OF KENTUCKY
Authorization for Disclosure of Protected Information
PLEASE PRINT LEGIBLY

This form must be completed to authorize the disclosure of protected information.	
I HEREBY AUTHORIZE THE DEPARTMENT FOR COMMUNITY BASED SERVICES IN THE CABINET FOR HEALTH AND FAMILY SERVICES TO DISCLOSE AND USE THE SPECIFIED INFORMATION BELOW.	
Individual Requesting Records: Name (Print)	Address
City, State, Zip Code	
Telephone Number (Home) (Work)	
Please Send Records To: Name (Print)	Address
City, State, Zip Code	
Telephone Number (Home) (Work)	
Email Address to Receive Encrypted Results	
The name of the individual whose information you authorize the disclosure of:	
Social Security Number	Date of Birth
Case Record # (if known)	County where case record is maintained
I request to inspect the following document(s):	
The purpose for disclosure is: **(Note: Must complete, Do Not Leave Blank)**	
Please attach a copy of photo ID for verification	
The specific protected information you authorized the disclosure of: ☐ Medical History ☐ Immunizations ☐ Treatment Information ☐ Developmental Information ☐ Benefits Eligibility Records ☐ Payment Records ☐ Medicaid Claim Information ☐ Child Protective Services Information (Provide Court Custody Order, Court Order or Birth Certificate) ☐ Adult Protective Services Information (Provide Court Order or POA) ☐ Other_____	

CHFS-305
922 KAR 1:510
(R. 11/2021)

Please read carefully

- Complete this form and submit it within ten (10) days to the **Cabinet for Health and Family Services, Department for Community Based Services, Records Management Section, 275 East Main St., Section 3E-G, Frankfort, Kentucky, 40621, OR submit completed form with legible ID to CHFSDCBS.RMS@ky.gov.**
- I understand this authorization will expire in ninety (90) days.
- I understand I have the right to revoke this authorization at any time, however I must do so **in writing**. I further understand that actions already taken based on this authorization prior to revocation will **not** be affected.
- I understand I have the right to a copy of this authorization.
- I understand that authorizing the use/disclosure of public information is voluntary. I need not sign this authorization in order to assure service. I may request to inspect or receive a copy of information to be used or disclosed, as provided in 45 CFR 164.524. I further understand that any disclosure carries with it the potential for an unauthorized disclosure and the information may not be covered by federal confidentiality rules.
- I understand that information may be subject to re-disclosure and no longer protected.
- The following statement applies to any alcohol and/or drug abuse treatment information disclosed. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations, 42 CFR Part 2, prohibit you from making further disclosures without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure is **not** sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my information.

Signature _____ Date_____

THIS FORM MUST BE COMPLETE

Records Requests Fee: The charge is ten cents ($0.10) per page after twenty (20) pages, plus postage. Please do not send money with this request. This office will notify you of the amount due once the records are available.

LOUISIANA DEPARTMENT OF HEALTH

Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid # or Social Security #

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

❒ **TO RELEASE Information TO OR** ❒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians
❒ Research related treatment ❒ Creating health information for disclosure to a third party.
❒ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)
❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
❒ Alcoholism † ❒ Drug Abuse † ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness *(If signed with an "X" or mark)* Date

For LDH Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

† Provider shall be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 - Prohibition on redisclosure.

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of health information for:

- Psychotherapy notes
- Employment-related determinations by an employer
- Research purposes unrelated to your treatment
- Substance Use (Alcohol and Drug Use)

When required by law or policy, LDH may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, LDH will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by LDH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to LDH.

You may cancel an authorization in writing at any time. LDH can not take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by LDH privacy policies.

YOUR RIGHT TO FILE A PRIVACY COMPLAINT

You may contact the privacy office listed below if you want to file a complaint or to report a problem about how LDH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. LDH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful.

Your Privacy office contact is:

State of Louisiana - Louisiana Department of Health
Office of Secretary - Privacy Office
Post Office Box 629
Baton Rouge LA 70821-0629
Email: privacy–LDH@la.gov

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1 Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2 If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3 In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4 Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5 Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information.

This helps prevent others from changing your form.

EXAMPLE: jh All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6 Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7 Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8 This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9 Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

THE GREAT SEAL OF THE STATE OF MINNESOTA 1858

AUGUST2015

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ / ___ / _____ (MM / DD / YYYY) Previous name(s) _____

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

2 Contact for information about how this form was filled out (optional):

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (MM / DD / YYYY) (optional)

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical
☐ Laboratory report
☐ Emergency room report
☐ Surgical report
☐ Medications
☐ Mental health
☐ Discharge summary
☐ Progress notes
☐ Care plan
☐ Immunizations
☐ HIV/AIDS testing
☐ Radiology report
☐ Radiology image(s)
☐ Photographs, video, digital or other images
☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date ___ / ___ / _____
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ / ___ / _____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

AUGUST2015

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Authorization for the Use/Disclosure of Protected Health Information

Return Forms To:
Mississippi State Department of Health
Attn: OHIT Epic
570 East Woodrow Wilson Drive
P.O. Box 1700
Jackson, MS 39215-1700
Toll-free: 1-866-458-4948 | Fax: 601-576-7110

Si necesita esta información en español, consulte a su proveedor de MSDH o llame 1-866-458-4948 o comuníquese con su oficina local de MSDH. Información de contacto de las oficinas esta localizado en el sitio web de MSDH http://www.msdh.ms.gov.

Authorization Section:

I, _____
(Patient's Name – first, middle, last, maiden)
hereby voluntarily authorize the Mississippi State Department of Health (MSDH) to disclose my protected health information (PHI) in accordance with the following: *(please complete all sections)*:

A. Information to be disclosed:
Only the period of events from: _____ to _____

Only Information Related to (*please check off all that applies*):

- ☐ **Breast and Cervical Cancer Program**
- ☐ **Child Health**
- ☐ **For CMP Use Only** _____
- ☐ **Complete Medical Record**
- ☐ **Consultation Reports*** _____
- ☐ **Diabetes**
- ☐ **Early Intervention**
- ☐ **Early and Periodic Screening (EPSDT)**
- ☐ **Comprehensive Reproductive Health (Family Planning)****
- ☐ **Financial Records**
- ☐ **Genetics**
- ☐ **HIV/AIDS ****
- ☐ **Hospitalization**
- ☐ **Hypertension**
- ☐ **Job Related*** (specify)** _____
- ☐ **Laboratory Test *** _____
- ☐ **Maternity (Prenatal)**
- ☐ **Medical History *** _____
- ☐ **Medication Records**
- ☐ **Progress Notes*** _____
- ☐ **STD (other than HIV/AIDS) ****
- ☐ **Other (specify)*** _____

☐ Psychotherapy notes ONLY. *Requests for psychotherapy notes cannot be combined with any other Authorization; if you wish to authorize the disclosure of psychotherapy notes in addition to other information, please fill out a separate Authorization form for the additional information.*

Required: By authorizing MSDH to disclose your PHI, are you also giving MSDH permission to disclose your information regarding alcohol and substance use, genetic test results, HIV/AIDS, mental health (*excluding psychotherapy notes*), and sexually transmitted diseases (STDs)? ☐ Yes ☐ No

B. For the purpose of: ☐ Further medical care ☐ Personal Use ☐ Attorney ☐ Insurance ☐ School ☐ Disability ☐ Research ☐ Other: (*specify*)_____

C. Release Information to the following person/organization: *(a separate authorization form must be filled out for each person/organization)*

_____ _____
(Name of person/organization) *(If organization - name of person to receive mail)*

_____ _____
(Mailing address) *(City)* *(State)* *(Zip)*

_____ _____
(Telephone number) *(Fax number)*

_____
(E-mail address)

D. **Charges.** I understand the entity requesting access to my records may be charged a reasonable fee of $0.50 per page for copies (single-sided), a $10.00 base rate for clerical assistance, and $14.00 flat rate for Office of Disability Determination Services. If the cost of copies is expected to be substantial (greater than $25.00), MSDH should provide to me an estimate of the cost before making the copies.

E. **Effective time period.** This Authorization is valid for six months (6) months from the effective date of signature, or until revocation, death of the patient, or the patient reaches the age of majority, whichever occurs first, unless one of the following boxes is checked:

☐ This Authorization is valid for this one (1) time disclosure.
☐ This Authorization is valid for release to my attorney throughout the course of representation at his/her request.
☐ This Authorization is valid until the following expiration date: _____

F. I understand that I am under no obligation to sign this Authorization. I understand that I may revoke this Authorization at any time by signing the Revocation Section of this form and returning it to the above address. I understand that any such revocation does not apply to the extent that persons authorized to disclose my information have already acted in reliance on this Authorization.

G. I understand that my ability to obtain treatment, payment, enrollment, or eligibility for care will not depend on whether I sign this Authorization, except if: (1) the information is necessary to determine my enrollment or eligibility and it is not for the disclosure of psychotherapy notes, (2) such care is research related, or (3) such care is provided solely for the purpose of creating PHI for disclosure to a third party.

H. I understand that information disclosed pursuant to this Authorization, except for alcohol and drug abuse as defined by 42 C.F.R. Part 2, may be re-disclosed by the recipient to additional parties and may no longer be protected.

Signature: By signing below, I hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

_____ _____
(Patient Name) *(Date of birth – mm/dd/yyyy)*

_____ _____
(Social Security Number – xxx/xx/xxxx) *(Patient Identification Number)*

_____ _____
(Mailing address) *(City)* *(State)* *(Zip)*

_____ _____
(Telephone number) *(E-mail address)*

_____ _____
(Signature) *(Date signed – mm/dd/yyyy)*

_____
(Printed Name of Signer)

If not signed by the patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient: _____

* Identify Program by Name
** Authorization to release Family Planning, STD, and HIV/AIDS records can only be obtained from the patient named on the record.
*** Medical information pertaining to treatment or a condition that is related to absence from work, return to work, and/or any specific restrictions such as but not limited to typing, physical locomotion, driving, lifting, standing, or sitting.

Revocation Section:

I, _____
(Patient's Name – first, middle, last, maiden)

hereby voluntarily revoke this Authorization for the Disclosure of Protected Health Information.

Signature: By signing below, I hereby swear and affirm that the above statement is true and correct to the best of my knowledge.

_____ _____

** *(Signature)* *(Date signed – mm/dd/yyyy)*

** ***If not signed by the patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient:*** _____

Missouri Department of SOCIAL SERVICES
Your Potential. Our Support.

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ authorize and request
(NAME OF CLIENT, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

- ☐ Department of Social Services (DSS)
- ☐ Division of Youth Services (DYS)
- ☐ MO HealthNet Division (MHD)
- ☐ Division of Finance & Administrative Services (DFAS)
- ☐ Missouri Medicaid Audit and Compliance (MMAC)
- ☐ Family Support Division (FSD)
- ☐ Children's Division (CD)
- ☐ Division of Legal Services (DLS)
- ☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DCN	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES FROM (DATES)

IV-D NUMBER (REQUIRED FOR REQUESTS FOR CHILD SUPPORT RECORDS)

to **(check all that apply)**

- ☐ Attorney: _____
- ☐ Legislator/Staff: _____
- ☐ Other _____
(NAME OF FACILITY, AGENCY, PERSON)
_____
(ADDRESS, CITY, STATE, ZIP)
- ☐ Employer: _____
- ☐ Governor's Staff: _____

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- ☐ Eligibility Determination
- ☐ Employment
- ☐ Continuity of Services/Care
- ☐ Legal Consultation/Representation
- ☐ Complaint/Investigation/Resolution
- ☐ Background Investigation
- ☐ Legal Proceedings
- ☐ Treatment Planning
- ☐ At Consumer's Request
- ☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)
- ☐ Other (specify) _____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☐ Entire File
- ☐ Licensure Information
- ☐ Medical/Psychiatric Evaluation/Treatment Records
- ☐ Benefits Received
- ☐ Hotline Investigations
- ☐ Home Studies
- ☐ Completed Fraud Investigations
- ☐ Eligibility Determinations
- ☐ Substance Abuse Treatment
- ☐ Client Employment Records
(NOTE: THIS DOES NOT INCLUDE THE RELEASE OF EMPLOYMENT RECORDS FOR DSS EMPLOYEES)
- ☐ Other _____

Note: Information pertaining to third parties in your records may be redacted or withheld entirely unless those persons authorize the department, in writing, to release their information to you. Other information may be redacted when required by law.
Note: Requests for DSS records may be subject to the collection of reasonable fees prior to the release of records.

1. **READ CAREFULLY:** I understand that my information and records with the Department of Social Services are confidential by law. I understand that by signing this authorization, I am allowing the release of any and all of my information and records which I am authorized to receive as specified on this document whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise authorized. The protected information in my records may include medical treatment and/or evaluation information, mental/behavioral health information, information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable or environmental diseases and conditions, alcohol/drug abuse, application for and/or receipt of public assistance benefits, alcohol/drug abuse information, and/or information concerning child abuse and neglect.
2. This authorization includes both information presently compiled and information to be compiled during your association or dealings with the Department of Social Services, during the specified time frame.
3. Unless otherwise indicated, this authorization becomes effective on the date of signature below and will expire one year from that date. If you would like to specify a different expiration date, please indicate that date here: _____
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the Privacy Officer of the Department of Social Services at 221 W. High Street, Room 230, Jefferson City, MO 65102. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
5. I understand that I have the right to receive a copy of this authorization upon request. **A photographic copy of this authorization is as valid as the original.**
6. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive services from the Department of Social Services. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Sections 155.260 and 164.524. I understand that any disclosure of information carries with it the potential for redisclosure by the party receiving it and that the information may no longer be protected by law once it is in the possession of the receiving party. If I have questions about disclosure of my information, I can contact the Privacy Officer of the Department of Social Services, my caseworker or family support eligibility specialist.

My signature below acknowledges that I have read and understood the text above, and authorize the release of my confidential information.

SIGNATURE OF CLIENT	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	

(Please include a Description of Authority to Act on Client's Behalf and attach a copy of the Document Granting Authority, where applicable.)

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION

Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing in the block below, I am allowing the release of any alcohol and/or drug information or records (if any) that I may have to the agency or person specified on this form. Prohibition of Redisclosure: Federal regulations (42 CFR Part 2) prohibit the recipient of substance abuse treatment records from making further disclosure of those records without the specific written authorization of the person to whom those records pertain, or as otherwise specified by such regulation. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose. **Sign below if you wish to authorize the release of alcohol and drug abuse information.**

SIGNATURE OF CLIENT/PARENT OR LEGAL GUARDIAN (IF APPLICABLE)	DATE

NOTICE OF REVOCATION

EFFECTIVE DATE

I, _____, (Client) hereby revoke my authorization of this disclosure of information to the Agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CLIENT	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Privacy Officer of the Department of Social Services at 221 W. High Street, Room 230, Jefferson City, MO 65102.

AUTHORIZATION
For the Use and Disclosure of Protected Health Information

Montana Department of Public Health and Human Services
PO Box 4210, Helena, MT 59604-4210

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits your Protected Health Information (PHI) from being shared without your permission except in certain situations. By signing this form, you are giving us permission to share the health information you indicate below. *This does not keep the information from being shared with more people once it leaves our office*. You may cancel this Authorization at any time by signing the AUTHORIZATION REVOCATION below and returning it to the Department of Public Health and Human Services (DPHHS).

Name of Individual or Entity you are authorizing to receive your Protected Health Information:

_____

I give permission to the Department of Public Health and Human Services to share the Protected Health Information indicated below with the Individual or Entity listed above:

- ☐ All information
- ☐ Information from a specific time period (specify dates):

  From _____ To _____
- ☐ All information relating to a certain event or injury *(Example: left knee injury from December 2009, specify event and dates.)*

  Event_____ Date: _____
- ☐ Other (specify) _____

Client Name: _____Program ID Number (if applicable): _____

Signature: _____ Date: _____

EXPIRATION: no later than thirty (30) months from the date of signature, or according to an expiration date or event you specify below, whichever is earlier:

_____

AUTHORIZATION REVOCATION:

I no longer want my Protected Health Information shared with the individual/entity above.

Signature _____**Date** _____

Date: 08/2018

Print Form Save Form Reset Form

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Authorization for Disclosure of Protected Health Information

Failure to sign this form will not affect treatment or payment, however it may affect enrollment, or eligibility for certain benefits provided by the Nebraska Department of Health and Human Services. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me. I also understand that I am not required to disclose my social security number, though disclosure may make it easier or quicker for information to be provided.

Client Name (Last, First, Middle Initial)		Date of Birth
Social Security Number	Case/Chart # (if known)	Period Covered Admission of:

Information will be disclosed to:	**Reason for Disclosure:**
Name:	☐ Eligibility Determination ☐ My Request ☐ Insurance Claim ☐ Legal Purposes ☐ Consultation and/or Treatment ☐ Planning ☐ Other (be specific): _____
Address 1:	
Address 2:	
City, State, Zip:	
The information to be released pursuant to this authorization is limited to records or information from or in the possession or control of DHHS (or other party, as applicable).	

Specific Information to be Disclosed:

☐ All other non-medical information, records, or documents relating to me which the Department of Health and Human Services could release directly to me.
☐ Entire Medical Record

OR:

☐ Aftercare Referral Form
☐ Discharge Summary
☐ Diagnosis
☐ History & Physical Examination
☐ Laboratory
☐ Medications
☐ Progress Notes
☐ Psychiatric History & Treatment
☐ Psychological Evaluation & Treatment
☐ Social History
☐ X-rays & Other Diagnostic Imaging Results
☐ Alcohol and/or Drug Abuse Treatment
☐ Genetic Testing Information
☐ HIV/AIDS Information
☐ Sickle Cell Anemia Information
☐ Other (be specific): _____

This Authorization (unless revoked earlier in writing) shall terminate on_____ (must have date or event filled in). By signing this authorization, I acknowledge that the information to be released may include material that is protected by federal or state law, including benefit or enrollment information; or protected health information that may include Drug/ Alcohol, HIV, or sickle cell anemia related information. My signature authorizes release of indicated information. I also understand this authorization may be revoked at any time by submitting a written request in accordance with the then current DHHS Notice of Privacy Practices (if to DHHS), or by submitting a written request to the health care provider, health care entity, or otherwise (if to anyone else),a n d it will be honored with the exception of information that has already been released. I also understand if the recipient of the information is not a health plan or health care provider, the information may no longer be protected by privacy laws.

Client's Signature		Date
Authorized Representative's Signature	Authorized Representative's Printed Name	Date
Authorized Representative (Select One): ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Personal Representative		
Witness's Signature	Witness's Printed Name	Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (including Federal Regulations, 38 CFR 1.460-1.499, 42 CFR Part 2 and Part 431, Subpart F) which prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. The federal rules restrict the use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 2.65 . A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PLEASE FILL OUT THIS FORM COMPLETELY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Nebraska Department of Health and Human Services "DHHS" and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

PRACTICES AND USES:

DHHS may access, use and share medical information without your consent for purposes of:

- **Treatment:** We may use your medical information to provide you with medical treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the hearing process. Different agencies within DHHS may share your medical information in order to coordinate the different things you need, or to support and maintain your continuum of care.
- **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a surgery you received at the hospital so the hospital can be reimbursed.
- **Operations:** We may use and disclose medical information about you for health care operations. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff.

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE WITHOUT CONSENT/AUTHORIZATION:

- **Required By Law:** We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Food and Drug Administration:** We may disclose your Protected Health Information as required by the Food and Drug Administration.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law.
- **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- **Criminal Activity:** We may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel for military, national security, and intelligence activities. Protected Health Information may be disclosed for the administration of public benefits purposes.
- **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- **Required Uses and Disclosures:** We must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

USES AND DISCLOSURES REQUIRING AUTHORIZATION:

There are certain uses and disclosures of Protected Health Information that require your authorization. Among them are: most uses and disclosures of psychotherapy notes; uses and disclosures of protected health information for marketing purposes; and disclosure of protected health information that constitutes a sale. Other uses and disclosures not described in this notice will be made only WITH authorization from you. You may revoke this authorization at any time as provided by 45 CFR 164.508(b)(5).

YOUR RIGHTS TO PRIVACY:

- **Right to Inspect and Copy.** You have the right to inspect and copy your medical information. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit a written request at the Site of Service or to the DHHS HIPAA Privacy & Security Office. If you request a copy, we may charge a fee for the cost of copying, mailing, and other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request the denial be reviewed.
- **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend (correct) the information. You have the right to request an amendment as long as the information is kept by or for DHHS. To request an Amendment, your request must be made in writing and submitted at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for DHHS;
  - Is not part of the information which you would be permitted to inspect and copy; or,
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. You must submit your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, health care operations, and to someone who is involved in your care or the payment of your care, like a family member or friend. We are not required to agree to your request for restrictions unless it is for payment or health care operations and you use your own funds to pay, in full, for a health care item or service. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of this Notice. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, http://dhhs.ne.gov/Pages/hipaa_hp-1-p-notice.aspx or by contacting us.
- Opt out of fundraising communications. If DHHS should conduct fundraising activities, you have a right to opt out of this communication.
- Breach notification. In the event DHHS breaches your unsecured protected health information as defined by HIPAA, you will receive notification of the breach.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with DHHS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with DHHS, you may contact the DHHS HIPAA Privacy & Security Office. To file a complaint with HHS, contact: Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748), 1-866-778-4989-TTY. You will not be penalized for filing a complaint.

CHANGES TO THE NOTICE OF INFORMATION PRACTICES

The State of Nebraska Department of Health and Human Services reserves the right to amend this Notice at any time in the future. Until such amendment is made, DHHS is required by law to abide by the terms of this Notice. DHHS will provide notice of any material change in revision of these policies either electronically or in paper format.

CONTACT INFORMATION

This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at DHHS please direct them to: HIPAA Privacy and Security Office, 301 Centennial Mall South 3rd Floor, Lincoln, NE 68509-5026, by phone at 402-471-8417, or by email to DHHS.HIPAAOffice@nebraska.gov . If you have question about your benefits call 800-383-4278. Effective:9/23/2013

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:

_____ _____

Signature of Recipient Date

Relationship to Recipient_____

STEVE SISOLAK
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

STEVE H. FISHER
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____
Case Name: _____
Case ID: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____ **SSN:** _____

You are authorized by the undersigned to release to or obtain from the Nevada State Division of Welfare and Supportive Services the information including, but not limited to, that indicated below. This authorization constitutes a full and complete release from any liability resulting from disclosure of such information. I hereby consent to the disclosure of my identity and waive my right as an older person to have my identity kept confidential. This authorization also permits release of medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (P.L. 93-282). A photocopy of this form shall be as valid as the original.

☐	Authorization for medical data including, but not limited to, admission history and physical progress notes, discharge summary, operative report, laboratory test results and consultant reports.
☐	Authorization for undefined

This authorization for release shall be valid for one (1) year.

Signature	Print Name	Title/Relationship	Date	Telephone Number

Please return this form to the address above.

State of New Jersey
Department of Human Services
P.O. BOX 700
Trenton NJ, 08625

Authorization to Disclose Information

I, _____ understand that my information, which is retained by the New Jersey State Department of Human Services and/or one of its agencies, may not be disclosed to a third party without my expressed written authority, unless permitted or required by law. I hereby authorize the New Jersey State Department of Human Services to disclose my information to:

Individual's Name or Class of Individuals _____

_____

Organization/Entity (if applicable): _____

Address: _____

Telephone Number: _____ **Fax Number**: _____

Describe the information to be disclosed. (Check all that apply):

[ ] Entire medical record

[ ] Partial medical record

[ ] Demographic information

[ ] Other information

Identify the specific information to be disclosed. (Please use descriptors, including but not limited to dates, services, level of detail to be released, etc.)

This authorization shall be in force and effect until: _____
Date or Event of Expiration

_____, at which time this Authorization expires. I understand that upon this expiration date, the New Jersey State Department of Human Services will no longer provide my information to the person or persons stated above, and that if I wish for this person or persons to continue to receive information, I must execute another authorization.

I understand that:

- I have the right to revoke this Authorization, in writing, at any time, except to the extent the New Jersey State Department of Human Services has taken action in reliance on this authorization. The process of and exceptions to revocation are fully detailed in the DHS Notice of Privacy Practices. The effective date of the revocation is the date on which the revocation was received by a Department employee.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Department of Human Services, federal law or state law.
- The person or class of persons named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.
- This Department and its agencies will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
- If I am authorizing the disclosure of my **substance abuse information**, I must state the purpose of the disclosure. My purpose in allowing the Department to disclose this information is as follows:

_____

_____

By signing below, I fully acknowledge and agree to the above terms.

_____ _____
Signature of Individual or Personal Representative | Date

If you wish to file a complaint with our agency or get more information on how you can file a complaint with the Department of Human Services, please contact the Privacy Officer in the Office of Legal & Regulatory Affairs, P.O. Box 700 Trenton, NJ 08625, or the Office of Civil Rights, US Department of Health & Human Services, 26 Federal Plaza-Suite 3312, New York, NY 10278.

FOR OFFICE USE ONLY:

Date received _____

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Authorization to Release Protected Medicaid Member Information to a Third Party

Medicaid Member Name (required): _____

Date of Birth (required): ____ / ____ / ____

At least one of the following identification numbers is required, preferably both.

Client Identification Number (CIN): _____

Social Security Number (SSN): ____ – ____ – _____

Persons/organizations authorized to receive or use the information:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) ____ – _____

Dates Authorized: ☐ All OR From: ____ / ____ / ____ To: ____ / ____ / ____ OR ☐ To Present

Purpose of the use/disclosure: _____

1. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for the health plan's eligibility or enrollment determinations relating to the individual.
2. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.
3. I may revoke this authorization at any time by notifying the Department of Health in writing at the address below, but, if I do, it will not have any effect on actions that the Department took before they received the revocation. If not previously revoked, this authorization will expire upon completion of this request or one year from the date this form is signed, whichever comes first.
4. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, and therefore the recipient of the confidential data may re disclose the confidential data.

By signing this form, I understand that I am allowing the New York State Department of Health to use or disclose all of the payment information for the Medicaid Member as indicated above, including data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse. I specifically authorize release of such information to the person(s) indicated above as the recipient.

_____ _____
Signature of Medicaid Member or Agent Date

_____ _____
If not member, name of person signing for member Authority to sign on behalf of member

_____ _____
Witness Signature Witness Name

Please return to: Medicaid Data Warehouse – CDRs
NYSDOH – MISCNY
ESP P1-11S Dock J
Albany NY 12237

Oklahoma HealthCare Authority

STATE OF OKLAHOMA
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105 (405) 522-7300

Release Information Form

SoonerCare Member Name: _____
SoonerCare ID#: _____
Social Security Number: _____
DOB: _____

1. I authorize the OHCA to release the above individual's Medicaid information as described below.

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

3. This information may be released to the following: (One individual only.)

Name: _____
Address or PO Box: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone: _____ **Fax:** _____

4. For the purpose of:

5. I understand that I can change this authorization at any time. I understand that I must change this authorization in writing to OHCA. I understand that information may have already been released based on this authorization. Unless changed, this authorization will expire on the following date: _____ . If I don't put a date, this authorization will expire in six months.

6. I understand that signing this release is voluntary, and a refusal to sign does not affect my receipt of Medicaid services. I may inspect or obtain a copy of the information to be released.
Under penalty of law, I represent that I am, in fact, the undersigned, or his/her legal representative.

Signature of Patient or Legal Representative *(Legal representative must show relationship to patient):*

X _____ **Date:** _____
Print Name: _____
Relationship to patient: _____

Signature of Witness
X _____ **Date:** _____
Please Allow At Least 15 Days For Processing.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize_____
(Name and address of facility/health care provider you wish to release information)

To release information requested for (either DOB or SID is REQUIRED to identify record):

_____ **D.O.B.**_____ **S.I.D.**_____
(Name of person making request) **(Date of Birth)**

To: _____ **For the purpose of** _____

_____ _____

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist:

____All hospital records (including nursing records and progress notes)
____Transcribed hospital reports **____Pathology reports** **____Other (Explain Below)**
____Medical records needed for continuity of care **____Diagnostic imaging reports** _____
____Most recent five year history **____Clinician Office Chart notes** _____
____Laboratory reports **____Dental records**
____Emergency and Urgency care records
____Please send the entire medical records (All information) to the above named recipient

I authorize the information listed below to be used, disclosed, or received by placing my INITIALS next to the information:

_____*HIV/AIDS – related records (Copies will not be released to inmates while incarcerated)
_____*Genetic testing information
_____* Mental Health-list specific info requested _____
_____ Alcohol and Drug information**

**PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Must be initialed to be included in other documents. Records will not be released without your initials specifying that you have granted this specific release authority.

This authorization is limited to the following time period:_____
This authorization is limited to a worker's compensation claim injuries of:_____

My signature indicates that I authorize the disclosure of the above information and understand the following:

I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.

I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand this change will not affect information that has already been shared.

I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

_____ _____
(Signature of Patient) **(Date)**

_____ _____
(Signature of legal/personal representative authorized by law) **(Date)**

CD728CH (3/11)

Commonwealth of Pennsylvania, Department of Human Services
Authorization for Use or Disclosure of Personal Information

1. I authorize the Department of Human Services to use/disclose individual information as described below from the records of:

Name: _____
Date of Birth: _____ Telephone: _____
Address: _____
ID number(s) (identify each type of number) _____
_____

2. Reason for disclosure: _____
_____
(Describe each specific purpose - if disclosure is at individual's request and information to be disclosed does not include drug and alcohol treatment information, may state, "At the request of the individual")

3. I understand that:

a. this authorization may be revoked at any time by writing to the individual/organization identified in section 1 except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

b. the Department and its health and human services programs will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.

c. information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified in section A.2 below and is no longer protected by federal privacy regulations.

d. the Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

e. I may refuse to sign this authorization.

PART A - General Information

A.1 Information to be disclosed and time period of information requested (Identify specifically the information to be used/disclosed such as welfare records, lien records, inspection records, etc. If information to be used or disclosed includes mental health, drug and alcohol, or HIV-related information, please complete section of this form that relates to that information):

A.2 This information is to be disclosed to:

_____
(Insert name or title of the individual/organization to whom disclosure is to be made)

A.3 This authorization expires as indicated:

_____ Once acted upon

_____ Other (specify date or event) _____

PART B - Special Categories of Medical Information

B.1 Drug and Alcohol Information

If my medical record includes drug and alcohol information, I want to send that information to the individual/organization identified in Part A of this form.

_____ Yes _____ No or Not Applicable

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B.2 Mental Health Information

If my medical record includes mental health information, I want to send that information to the individual/organization identified in Part A of this form.

_____ Yes _____ No or Not Applicable

B.3 HIV/AIDS Information

If my medical record includes HIV/Aids information, I want to send that information to the individual/organization identified in Part A of this form.

_____ Yes _____ No or Not Applicable

This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

* *

_____ _____

Signature of Individual or Personal Representative — Date

If personal representative, state relationship to individual:

_____

_____ _____

Signature of Witness — Date
(necessary for release of Mental Health and Drug and Alcohol information)

If individual is physically unable to sign, signature of second witness:

_____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Beneficiary Information

Beneficiary Name: _____
Last *First* *M.I.*

Beneficiary Date of Birth:_____ Medicaid ID: _____

Authorization and Description of Information to be Released

I,_____hereby authorize the South Carolina Department of Health and Human Services
Beneficiary Name or Legal Representative

to release specific health information from the records of the above named beneficiary for the specific purpose of: _____

_____

Specific information to be disclosed: _____

Recipient (person or organization that will receive your information)

Recipient: _____

Phone Number:_____Email: _____ Fax Number: _____

Address: _____
Street Address/P.O. Box *City* *State* *Zip Code*

I understand that this authorization will expire on the following date, event or condition: _____
Expiration Date, Event or Condition

I understand that if I fail to specify an expiration or end date, event or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time by completing the Revocation Form located on the South Carolina Department of Health and Human Services website and submitting the completed Form to: Privacy Official, Office of Civil Rights and Privacy; SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206. I further understand that any action taken on this authorization before submission of the Revocation Form is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without any further written authorization unless otherwise provided for by state or federal law.

_____ _____
Signature of Beneficiary *Date*

_____ _____
*Signature of Legal Representative** *Date*

*Documentation of the authority to act as the legal representative for the beneficiary must be attached.

Complete and use the button at the end to print for mailing

SD EForm - 2216 V1

State of South Dakota

HELP

CONSENT FOR RELEASE OF INFORMATION

I hereby give my consent to release the information described below **about**:

Patient/Participant Name:

Address:

City: State: SD Zip:

Date of Birth: Phone #

To the following person(s)/entities:

Name: Organization:

Address:

City: State: SD Zip:

From the following person(s)/entities:

Name: Organization:

Address:

City: State: SD Zip:

INFORMATION REQUESTED AND PURPOSE OF DISCLOSURE

☐ Medical/Clinical ☐ Demographic/Financial ☐ Business/Proprietary ☐ Adult ☐ Juvenile ☐ Other

☐ Other Specific Information Requested:

☐ Specific dates for Information Requested: to

☐ Purpose for Disclosure:

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. South Dakota State Agencies, their employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in State Agency Notice of Privacy Policies, this consent form may be cancelled at any time except to the extent the staff have taken action upon it. If not cancelled, this consent to release information will terminate in **one year** or upon the following specified date: . I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol information may not be redisclosed without consent.

I understand that my eligibility for, or enrollment in, State Agency Programs will not be based on whether I sign this consent form. Consent form complies with HIPAA provisions and must be signed.

Signature of Participant/Patient or Parent/Guardian Giving Consent Date

Print Name Relationship to Participant/Patient

Witness Signature Witness Name (print) and Relationship to Participant/Patient

Telephone number of the participant/patient for verification of the request for information

I cancel this request to release information effective immediately:

Signature Date

PRINT FOR MAILING CLEAR FORM

TEXAS Health and Human Services

Form 6700
August 2017-E

Use and Release of Health Information Authorization

Section I

Name: _____ Date of Birth: _____

Medicaid ID No. (*if known*): _____ **OR** SS No.: _____

By signing this authorization form, you are giving Texas Health and Human Services (HHS) permission to release all or part of your Medicaid claims history, which includes health information.

Section II – To be completed by client

I authorize HHS to release the information indicated at the bottom of Part A to the person or agency named in Part A, for the purpose(s) stated in Part B. My information will remain available to the person or agency indicated until the expiration date stated in Part B.

Part A – Release of information: I understand that my Medicaid claims history contains protected health information.

Check one of the following:

- ☐ Release **all** of my Medicaid claims history
- ☐ Release **only** the claims related to the accident and/or injury
- ☐ Release **only** the parts of my Medicaid claims history that relate to:
  - the following health care provider: _____
  - other (please describe in detail the health information you authorize HHSC to release):

_____

Release my information to the following Person/Agency: _____

Part B – Purpose(s) of Release: _____

This release expires six months following the final disposition of the claim or upon disposition of Medicaid funds.

Part C – Signature: _____ Date: _____

(Client or Personal Representative's Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:

_____

Note: *If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:*

Witness: _____ Date: _____

Section III: Notices to Client

- Once you authorize HHS to release your information, HHS is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.
- With a few exceptions, you have the right to request and be informed about the information that the HHS releases. You are entitled to receive and review the information upon request. You also have the right to ask HHS to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at 4900 N. Lamar Blvd., 4th Floor, Austin, Texas 78751.

Authorization for Release of Information

Washington State Health Care Authority

1 Health Care Authority is authorized to release information or records about

Last name, First name, Middle initial

Client I.D. or Social Security number

Address

City

State

ZIP Code

Phone number

If release is for information about dependent child(ren), list name(s) of dependent child(ren)

Reason/purpose for disclosure

☐ At the request of the individual ☐ Other:

Specific information to be used or disclosed (including dates, if needed; attach additional pages if more space needed)

The following types of information must be specifically authorized. This authorization includes information about the following (check all that apply):

☐ Sexually transmitted diseases

☐ Mental health

☐ HIV/AIDS test results, diagnosis, or treatment

☐ Chemical dependency treatment

Notice to those receiving information: If these records contain information about HIV/AIDS, sexually transmitted diseases, or drug or alcohol abuse, you may not further disclose that information under federal and state law without specific permission from the person and meeting specific legal requirements.

This authorization will expire in 180 days from the date signed below or on (give date or event)

2 Person or organization authorized to receive information or records

Name

Phone number

Address

City

State

ZIP Code

3 Signature

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time before the expiration date or event noted above by notifying the Health Care Authority in writing. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my continued coverage, eligibility and enrollment, or as allowed by law.
- The person or organization that I authorize to receive information about me or my dependent child(ren) might share it with another person or organization, and it might not be protected under the laws that apply to HCA.
- The Apple Health Notice of Privacy Practices and UMP Notice of Privacy Practices are available upon request by calling (844) 284-2149 or at **hca.wa.gov/pages/privacy.aspx**.

Form must be completed before signing. If signed by representative provide power of attorney or proof of guardianship.

Signature of enrollee or enrollee's representative	Date
Signature of child (if age 13 or older) representative	Date
Printed name of enrollee's representative	Relationship to enrollee

Provide copy of power of attorney or guardian papers.

Please return completed form to:

If Washington Apple Health (Medicaid) or CHIP
Health Care Authority
P.O. Box 45534
Olympia, WA 98504-5509

Email: **askmedicaid@hca.wa.gov**
Fax: 360-507 9068

If Public Employees Benefits Board Program or School Employees Benefits Board Program:
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Email: **ERBCORR@hca.wa.gov**
Fax: 360-725-0771

If subrogation:
Health Care Authority
P.O. Box 45561
Olympia, WA 98504-5561

Email: **HCACasualtyUnit@hca.wa.gov**
Fax: 360-753-3077

If request for disclosure of records:
Health Care Authority
P.O. Box 42704
Olympia, WA 98504-7204

Eamil: **PublicDisclosure@hca.wa.gov**
Fax: 360-507-9068

If constituent relations:
Email: **HCAConstituentRelations@hca.wa.gov**

Wyoming Department of Health

AUTHORIZATION TO RELEASE HEALTH RECORDS
WYOMING DEPARTMENT OF HEALTH

Client	Name (First, Middle, Last)	Previous Name(s)
	Current Address	
	Previous Address (if applicable) ☐ Update address and phone number	
	Date of Birth	Phone Number

Information Released FROM

☐ Aging Division
☐ Behavioral Health Division
☐ Healthcare Licensing & Surveys
☐ Immunization Unit
☐ Kid Care CHIP (Division of Healthcare Financing)
☐ Medicaid (Division of Healthcare Financing)
☐ Office of Emergency Medical Services (OEMS)
☐ Public Health Nursing (specify county): _____
☐ Public Health Division
☐ State Long-Term Care Ombudsman
☐ Veterans' Home of Wyoming
☐ Women, Infants, and Children (WIC)
☐ Wyoming Life Resource Center
☐ Wyoming Pioneer Home
☐ Wyoming Public Health Laboratory
☐ Wyoming Retirement Center
☐ Wyoming State Hospital
☐ Other (specify): _____

Information Disclosed TO

☐ **SELF OR** ☐ Individual/Facility/Organization (listed below)

Attn/Dept:	Phone Number	Fax Number	
Address	City	State	Zip

Delivery Method

Records should be sent by:

☐ Fax ☐ Mail ☐ Email _____
(Email Address)

☐ Pick up by Client or ☐ *Designee* _____
(Designee's Name)

For Child Caring Facilities Only:

☐ Direct access to client(s) immunization record in the Wyoming Immunization Registry (WyIR)

Information to be Released

Release the following records:

_____

Purpose of Disclosure	☐ Personal ☐ Continuity of Care ☐ Child Caring Facilities ☐ Other _____
Expiration	I understand this authorization will expire one year from the date it is signed, unless otherwise specified. (Alternative Expiration Date: _____)
Revocation	I understand I may revoke this authorization, in writing, at any time, except to the extent that the Wyoming Department of Health has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice stating my intent to revoke this authorization to the Wyoming Department of Health, Office of Privacy, Security & Contracts, 401 Hathaway Building, Cheyenne, WY 82002 or fax (307) 777-7439.
Charges	I understand I may be charged a reasonable fee to receive or direct to a third party a copy of the information identified above to be disclosed. The Wyoming Department of Health will notify me of any required fees so I may have an opportunity to agree, alter, or withdraw my request prior to processing.

I understand information disclosed may include information related to the treatment of behavioral, mental health, drug, alcohol, or sexually transmittable diseases. I understand information being disclosed may be subject to redisclosure by the recipient and may no longer be protected. I understand I am under no obligation to sign this authorization. I further understand the Wyoming Department of Health may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

All requests MUST be accompanied with proof of identity, such as a photocopy of the signatory's state-issued driver's license.

_____ _____ _____

Signature Print Name Date

Relationship to Client (if not client):

☐ Parent ☐ Legal Guardian ☐ Other (specify) _____

FOR OFFICE USE ONLY:

Reviewed By: _____ Date: _____

Proof of Identity Reviewed: ☐ Yes ☐ No

Notes:

_____

_____

☐ Approved ☐ Denied (correspondence reference number: _____)

Instructions for Completing the Wyoming Department of Health Authorization to Release Health Records

Client: Print the client's – full, legal name &/or any previous names
Address & previous address (if applicable)
If you would like a previous address changed to the current address, check the box.
Date of birth
Client's phone number (if we have questions)

Information Released FROM: Select the Wyoming Department of Health (WDH) divisions/programs/facilities you want to release your health information.

Information Disclosed TO: Print the name of the individual/facility/organization who is to receive the information along with their full/complete address, city, state, and contact number. If the information is being released directly to the client, select self.

Delivery Method: Select how we should send the information. Only the patient may pick up the information, unless the patient authorizes a designee. The WDH division/program/facility will call the client's phone number to provide notification that records are ready to be picked up and confirm pick up location.

Information to be Released: Specify the records to be released. Include dates if possible.

Purpose of Disclosure: Select the purpose of disclosure.

Expiration: The authorization will expire in one year unless specified otherwise.

Mail, fax, or email the completed and signed authorization with proof of identity to:

Aging Division 2300 Capitol Ave, 4th Floor Cheyenne, WY 82002 Fax: (307) 777-5340	Behavioral Health Division 122 W. 25th Street Herschler Bldg., 2nd Floor West, Suite B Cheyenne, WY 82002 Fax: (307) 777-5849	Healthcare Licensing & Surveys 2300 Capitol Avenue, Suite 510 Cheyenne, WY 82002 Fax: (307) 777-7127
Immunization Unit 122 W. 25th Street Herschler Bldg., 3rd Floor West Cheyenne, WY 82002 Fax: (307) 777-7996 Email: wdh-immrecords@wyo.gov	Medicaid / Kid Care CHIP 122 W. 25th Street Herschler Bldg., 4th Floor West Cheyenne, WY 82002 Fax: (307) 777-6964	Office of Emergency Medical Services 122 W. 25th Street Herschler Bldg., Suite 102E Cheyenne, WY 82002 Fax: (307) 777-5639
Public Health Nursing 122 W. 25th Street Herschler Bldg., 3rd Floor West Cheyenne, WY 82002 Fax: (307) 777-7278	State Long-Term Care Ombudsman 2300 Capitol Avenue, 4th Floor Cheyenne, WY 82002 Fax: (307) 777-7439	Veterans' Home of Wyoming 700 Veterans' Lane Buffalo, WY 82834 Fax: (307) 684-7636
Women, Infants & Children (WIC) 122 W. 25th Street Herschler Bldg., 3rd Floor West Cheyenne, WY 82002 Fax: (307) 777-5643	Wyoming Life Resource Center 8204 Wyoming Highway 789 Lander, WY 82520 Fax: (307) 335-6792	Wyoming Pioneer Home 141 Pioneer Home Drive Thermopolis, WY 82443 Fax: (307) 864-2934
Wyoming Public Health Laboratory 208 S. College Drive Cheyenne, WY 82002 Fax: (307) 777-6442 Email: WDH-LabResultRequest@wyo.gov	Wyoming Retirement Center 890 Highway 20 South Basin, WY 82410 Fax: (307) 568-3887	Wyoming State Hospital 831 Hwy 150 South Evanston, WY 82930 Fax: (307) 789-8181

If you are requesting health records from more than one Wyoming Department of Health division/program/facility, mail or fax the completed and signed authorization with proof of identity to the WDH Office of Privacy, Security & Contracts (OPSC), 401 Hathaway Building, Cheyenne, WY 82002 or Fax: (307) 777-7439. If you have any questions, please call OPSC at (307) 777-2990 or 1 (866) 571-0944.

Exhibit A-7

AUTHORIZATION FOR THE RELEASE OF WORKERS' COMPENSATION RECORDS

Name: _____

DOB: _____

SSN: xxx-xx-_____

I do hereby authorize [Name of Workers' Compensation Department], to release to

Ontellus
(Person or entity to whom records may be released)

and deliver, by mail or otherwise, to that person or entity at the following address:

910 Louisiana, Suite 4500
(Street Address)
Houston
(City)
Texas 77002
(State, Zip Code)

any and all records, documents and information in the Department's possession pertaining to any workers' compensation matter or matters involving me. These records, documents, and information may include, but are not limited to, first and subsequent reports of injury, claim file material including medical records and reports, settlement agreements, and awards. By affixing my signature below, I affirmatively consent to the release and disclosure of any and all such records and documents, and all information contained therein. I further affirmatively state I understand and acknowledge that by authorizing the release and delivery of this material I am waiving any right to claim the material to be released is exempt from disclosure.

_____ _____

Date [Name of Plaintiff]

Exhibit A-8

AUTHORIZATION FOR THE RELEASE OF DISABILITY CLAIMS RECORDS

Name: _____

DOB: _____

SSN: xxx-xx-_____

I do hereby authorize [Name of Disability Department], to release to

Ontellus
(Person or entity to whom records may be released)

and deliver, by mail or otherwise, to that person or entity at the following address:

910 Louisiana, Suite 4500
(Street Address)
Houston
(City)
Texas 77002
(State, Zip Code)

any and all records of disability claims of any sort for any disability claim(s) filed, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents concerning the above-named individual. By affixing my signature below, I affirmatively consent to the release and disclosure of any and all such records and documents, and all information contained therein. I further affirmatively state I understand and acknowledge that by authorizing the release and delivery of this material I am waiving any right to claim the material to be released is exempt from disclosure.

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

_____ _____

Date [Name of Claimant/Plaintiff]