

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

-----X

IN RE LEVAQUIN

PRODUCTS LIABILITY LITIGATION

-----X

THIS RELATES TO MDL DOCKET NO. 1943

PLAINTIFF: _____

(name(s))

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who was exposed to Levaquin®. Whether you are completing this fact sheet for yourself or for someone else, please assume that “You” means the person who was exposed to Levaquin®. In filling out this form, please use the following definition: “healthcare provider” means any hospital, clinic, center, physician’s office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out any section or sub-section of this form, please submit additional sheets as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information. This form requests information and documents about your medical condition for the past ten (10) years. However, defendants reserve the right to request additional information and information for a time period dating further back than ten (10) years on a case by case basis, at which time the parties will meet and confer as the issue arises. Further, defendants expressly reserve the right to request information and documents concerning all exposure(s) you had to Levaquin® at any time in your life, regardless of how long ago the exposure took place.

1. Name of person completing this form: _____
2. Name of person on whose behalf a claim is being made: _____
3. Please state the following for the civil action that you filed:
 - a. Case caption: _____
 - b. Docket Number: _____
 - c. Court in which action was originally filed: _____

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

Name: _____

Firm: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

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

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

- b. Current Address: _____

- c. In what capacity are you representing the individual or estate: _____

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

Court Which Appointed You: _____

Date of Appointment: _____

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

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

Date of Death: _____

**THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE
PERSON WHO WAS EXPOSED TO LEVAQUIN®**

I. PRODUCT IDENTIFICATION

1. Have you ever taken Levaquin®?

Yes ____ No ____

2. If yes, please provide the following information. Use additional pages to continue your answer if necessary:

a. Date(s) of prescription(s): _____

b. Use of each prescription identified above: Infection
.

c. Dosage (including how many times per day):

d. Name of the healthcare provider(s) who prescribed Levaquin®:

e. Name and address of the pharmacy/pharmacies where Levaquin® was obtained:

f. Reason for prescription:

3. Were you given any **written** instructions, warnings or other information about Levaquin®?

Yes ____ No ____ If Yes, describe the materials you received, identify who provided them, and state whether you or your attorneys still have the materials. (If you have the materials, please produce a copy.):

4. Were you given any **verbal** instructions, warnings or other information about Levaquin®?

Yes _____ No _____ If Yes, describe the information you received, when you received it and identify who provided it:

II. PERSONAL INFORMATION

1. Name: _____

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

3. Current Address and Date when you began living at this address _____

4. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

| Address | Dates of Residence |
|---------|--------------------|
| | |
| | |
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| | |

5. Social Security Number: _____

6. Date and Place of Birth: _____

7. Current Marital Status: _____

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

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

Yes _____ No _____

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

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

| Child's name and address | Date of birth |
|--------------------------|---------------|
| | |
| | |
| | |

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

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

13. Are you currently employed? Yes _____ No _____

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

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

If Yes, describe why you left:

14. Please identify all of your employers for the last 10 years, with name, address and telephone number, your employment dates, your position there, and your reason for leaving:

| Name of Employer | Address and Telephone Number | Dates of Employment | Your Position | Reason For Leaving |
|------------------|------------------------------|---------------------|---------------|--------------------|
| | | | | |
| | | | | |
| | | | | |

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

Yes _____ No _____

Branch and dates of service: _____

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

16. Identify each insurance carrier with whom you had health insurance coverage at any time in the past 10 years, and please include all private insurance and public assistance if applicable:

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

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

Yes _____ No _____

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

- a. Date (or year) of application _____
- b. Nature of claimed injury/disability: _____

c. To what agency or company did you submit your application: _____

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

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

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

19. Have you been convicted of, or pled guilty to, a felony and/or a crime of fraud or dishonesty within the past ten years?

Yes _____ No _____

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

20. Have you used a personal computer or laptop computer in the last ten years:

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

a. How long have you owned or had access to the computer: _____

b. Have you ever used a computer to look for information on the internet about Levaquin®, and/or to look for information about tendon injuries or fluoroquinolones manufactured or distributed by anyone else:

Yes _____ No _____ If Yes, describe the information or materials you located and state whether you have a printed copy of the materials. (If you have any materials please produce a copy.):

- c. Have any of your family, friends or anyone on your behalf used a computer to look for information on the internet about Levaquin®, and/or to look for information about tendon injuries or fluoroquinolones manufactured or distributed by anyone else:

Yes _____ No _____ If Yes, describe the information or materials located and state whether you have a printed copy of the materials. (If you have any materials please produce a copy.):

- d. Have you ever read or posted to any weblogs (blogs) or message boards regarding Levaquin®, and/or tendon injuries or fluoroquinolones manufactured or distributed by anyone else

Yes _____ No _____ If Yes, describe what you read or posted, and state whether you have a printed copy of the materials. (If you have any materials please produce a copy.):

21. Do you belong to any Levaquin® or fluoroquinolone-related activism or support groups?

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

- a. What is the name of the group and when did you join: _____
- b. Describe any written materials you have received from the group and the date they were received. (If you have any materials please produce a copy.):

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

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

IV. MEDICAL BACKGROUND

1. Smoking History

a. Have you ever smoked cigarettes? Yes _____ No _____

State amount smoked: _____ packs per day for _____ years, during the years _____ to _____.

b. Have you ever smoked cigars or pipe tobacco or used smokeless tobacco?

Yes _____ No _____

State amount smoked/utilized: _____ cigars/pipes/smokeless tobacco per day for _____ years, during the years _____ to _____.

2. Allergies and Allergic Reactions

Have you ever experienced an allergic reaction to any food, medication or pharmaceutical (including contrast agents)?

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

| Food, Medication or Pharmaceutical | When Allergy Diagnosed | Symptoms of Allergy | Health Care Provider Who Diagnosed Allergy |
|------------------------------------|------------------------|---------------------|--|
| | | | |
| | | | |

3. Other Conditions

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

| Condition Experienced or Diagnosed | Yes | No |
|---|-----|----|
| 1. Any tendon condition or injury, including tendonitis, tenosynovitis, tendinopathy, and tendon rupture. | | |
| 2. Any disorder or abnormality of blood vessels or circulatory system (e.g. aneurysm, arteriovenous malformation) | | |
| 3. Any cardiac condition (e.g. arrhythmia or dysrhythmia, heart attack, angina, congestive heart failure, cardiomyopathy, enlarged heart, coronary artery disease, blocked or narrowed arteries, heart valve conditions) | | |
| 4. Any skin condition (e.g. infections, eczema, psoriasis or any skin related infectious disease) | | |
| 5. Arthritis (e.g. osteoarthritis or rheumatoid arthritis) | | |
| 6. Autoimmune disease or condition or connective tissue disease or disorder (e.g. lupus, mixed connective tissue disorder, β 2-microglobulin amyloidosis, Lipodermatosclerosis/ chronic venous stasis, Morphea / lichen sclerosis et atrophicus, Raynaud's Syndrome, rheumatologic condition, Scleredema diabeticorum, scleroderma, scleromyxedema, Sjogren's Syndrome) | | |

| | | | |
|-----|--|--|--|
| 7. | Bleeding or clotting disorders or predispositions | | |
| 8. | Brain or neurological disorder (e.g. tumors, strokes, cerebrovascular disease) | | |
| 9. | Cancer (including blood cancers such as leukemia) | | |
| 10. | Chronic graft-versus-host disease | | |
| 11. | Chronic inflammatory conditions, such as inflammatory bowel disease, Crohn's disease or other pro-inflammatory diseases | | |
| 12. | Congenital disorders of any kind | | |
| 13. | Diabetes | | |
| 14. | Endocrine condition or disease (e.g. malfunction of the pancreas, parathyroid, thyroid, adrenal or pituitary, hyperparathyroidism, etc.) | | |
| 15. | Fibromyalgia | | |
| 16. | Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD, gallbladder disease, colitis, intestinal obstruction) | | |
| 17. | Genetic disorders or traits (e.g. Sickle cell anemia) | | |
| 18. | Hepatorenal syndrome | | |
| 19. | High blood pressure or low blood pressure | | |
| 20. | High cholesterol or triglycerides; hyperlipidemia or lipid metabolism disorders | | |

| | | | |
|-----|--|--|--|
| 21. | Infectious disease (e.g., tuberculosis, pneumonia, rheumatic fever, typhoid fever, encephalitis, poliomyelitis, malaria) | | |
| 22. | Immunosuppression (e.g. HIV/AIDS) | | |
| 23. | Kidney disease or condition (e.g., renal insufficiency, acute or chronic renal failure, end-stage renal disease, cysts, pruritus of renal disease/ neuropathy) | | |
| 24. | Kidney transplant or any other transplant surgery or attempted surgery | | |
| 25. | Liver disorder or disease (e.g. cirrhosis, hepatitis) | | |
| 26. | Lung disease (e.g. chronic obstructive pulmonary disease, chronic lung disease, emphysema, asthma, pulmonary hypertension or other lung disease) | | |
| 27. | Neurological disease or condition (e.g. multiple sclerosis, ALS, Parkinson's disease, Alzheimers) | | |
| 28. | Neuromuscular disorders (e.g. paralysis or any condition affecting movement or mobility) | | |
| 29. | Sexually transmitted diseases or infections (e.g.: syphilis, gonorrhea, Chlamydia, herpes) | | |
| 30. | Sleep Apnea | | |
| 31. | Thrombotic events (e.g. heart attack, transient ischemic attack, stroke, deep vein thrombosis, portal vein thrombosis or pulmonary embolism) | | |

| | | |
|---|--|--|
| 32. Vascular disease (e.g. peripheral vascular disease, peripheral arterial disease, vasculitis, phlebitis) | | |
|---|--|--|

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

| Condition You Experienced | Approximate Date of Onset | Name, Address and Telephone Number of Treating Physician (if any) |
|---------------------------|---------------------------|---|
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4. Surgeries/Procedures

For each surgery (invasive or non-invasive), procedure or therapy (including radiation therapy, hyperbaric oxygen therapy, immunotherapy, etc.) that you have undergone in the past ten years, please provide the information requested below:

| Date | Procedure | Facility | Physician Ordering | Physician Administering | Purpose |
|------|-----------|----------|--------------------|-------------------------|---------|
| | | | | | |
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V. MEDICATIONS

1. List all of the medications you currently take.

| Medication | Dose/ Frequency | Physician Ordering | Pharmacy Dispensing | Purpose |
|------------|--------------------|-----------------------|------------------------|---------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

2. To the best of your recollection, do you currently take or have you ever taken in the past ten years, any of the following medications, pharmaceutical products, supplements, or herbal remedies:

| Name of Medication | Yes | No | If yes, date(s) taken and prescribing doctor | Name and address of pharmacy where obtained |
|--|-----|----|--|---|
| Ciprofloxacin, norfloxacin, ofloxacin, enoxacin, lomefloxacin, or other fluoroquinolones | | | | |
| Herbal remedies | | | | |
| Vitamins | | | | |
| Amphetamines | | | | |
| Antibiotics, besides fluoroquinolones | | | | |
| Anti-depressants | | | | |
| Anti-inflammatories | | | | |
| Anxiety medications | | | | |
| Anti-rejection medications | | | | |
| Blood pressure medications | | | | |

| Name of Medication | Yes | No | If yes, date(s) taken and prescribing doctor | Name and address of pharmacy where obtained |
|--|-----|----|--|---|
| Blood thinners | | | | |
| Chemotherapy | | | | |
| Cholesterol medications | | | | |
| Diabetic medications | | | | |
| Diet medications | | | | |
| Heart Medications | | | | |
| Hormone therapy | | | | |
| Pain medications | | | | |
| Steroids, whether oral or injected, including but not limited to dexamethasone, prednisone, prednisolone, and methylprednisolone | | | | |
| CHOLESTEROL-LOWERING DRUGS | | | | |
| Lescol [Fluvastatin] | | | | |
| Lipitor [Atorvastatin] | | | | |
| Mevacor [Lovastatin] | | | | |
| Pravachol [Pravastatin] | | | | |
| Zocor [Simvastatin] | | | | |
| Niacin [Vitamin B3] | | | | |
| LoCholest [Cholestyramine] | | | | |
| Questran [Cholestyramine] | | | | |
| Prevalite [Cholestyramine] | | | | |

| Name of Medication | Yes | No | If yes, date(s) taken and prescribing doctor | Name and address of pharmacy where obtained |
|------------------------------------|-----|----|--|---|
| TRIGLYCERIDE-LOWERING DRUGS | | | | |
| Lopid [Gemfibrozil] | | | | |
| Tricor [Femofibrate] | | | | |
| Bezafibrate | | | | |
| Ciprofibrate | | | | |
| ANTI-INFECTIVE DRUGS | | | | |
| Diflucan [Fluconazole] | | | | |
| Erythrocin & Others [Erythromycin] | | | | |
| Flagyl [Metronidazole] | | | | |
| Nizoral [Ketoconazole] | | | | |
| Sporanox [Itraconazole] | | | | |
| IMMUNOSUPPRESSIVE DRUGS | | | | |
| Neoral [Cyclosporine] | | | | |
| Sandimmune [Cyclosporine] | | | | |
| OTHER | | | | |
| Anticoagulants | | | | |
| Heart Drugs | | | | |
| Thyroid Medications | | | | |
| Other | | | | |

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

| Name of Medication/Drug Used | Dates of Use (Approx.) | Who prescribed medication (i.e. doctor's name or clinic/hospital name) | Purpose |
|------------------------------|------------------------|--|---------|
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4. To the best of your recollection, are there any prescription medications other than those identified above that you have taken on a regular basis in the last ten (10) years for any duration more than two months?

Yes _____ No _____

If Yes, please identify the medication(s), the doctor(s) who prescribed it, the approximate dates/years you have taken this medication, and why it was given to you:

| Name of Medication/Drug Used | Who prescribed medication (i.e. doctor, clinic, or hospital name) | Date of use | Purpose |
|------------------------------|---|-------------|---------|
| | | | |
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VI. FAMILY MEDICAL HISTORY

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

| Condition | Date of Onset (Approx) | Relationship to You | Treatment | Outcome |
|-----------|------------------------|---------------------|-----------|---------|
| | | | | |
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VII. INJURIES & DAMAGES

1. Are you claiming any injury as a result of exposure to Levaquin®?

Yes _____ No _____

If Yes, please describe in detail your physical injury(ies) you claim were caused as result of your exposure to Levaquin®:

2. Are you claiming that exposure to Levaquin® caused you to have any tendon condition or injury, including tendonitis, tenosynovitis, tendonopathy, and tendon rupture?

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

a. Have you been diagnosed with any of these conditions? Yes _____ No _____

b. What healthcare provider diagnosed you with any these conditions and when?

c. What treatment have you undergone or are you undergoing?

d. What treatment options were considered?

3. Have you ever been hospitalized as a result any of these conditions? _____

Yes _____ No _____

If Yes, please provide the following information:

- a. Approximate date(s) of hospital admission: _____
- b. Approximate date(s) of discharge: _____
- c. Hospital name(s) and address(es): _____

4. Do you claim in this lawsuit that your exposure to Levaquin® caused or aggravated any psychiatric and/or psychological condition(s)?

Yes _____ No _____

If Yes, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s) since the age of 18 (or, if under 18, since birth):

| Condition | Name and address of mental healthcare provider (if any) | Approx. Dates/Years of Treatment/Visits (if any) |
|-----------|---|--|
| | | |
| | | |

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

Yes _____ No _____

If Yes, describe your claim and attach your W-2 forms or other tax documents for the past five (5) years:

VIII. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

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

Yes _____ No _____

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

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

Date of death: _____

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

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

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

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

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

IX. DOCUMENT DEMANDS

1. Authorizations: please sign authorizations that are attached hereto as Exhibit A, for each of the healthcare providers that you have identified above.
2. Documents in your possession, including writings on paper or in electronic form: If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.
 - a. Any and all of your medical records, medical billing records or insurance records in your possession, custody or control.
 - b. Copies of the entire packaging, including the bottle, box, label, and package insert for Levaquin®, as well as any remaining medication, and any pharmacy packaging and receipts for Levaquin®.
 - c. Copies of the entire packaging, including the bottle, box, label, and package insert, as well as any remaining medication, and any pharmacy packaging and receipts for any other prescription medication you took while taking Levaquin®.
 - d. A copy of all medical records and/or documents relating to the exposure to Levaquin® at any time in your life.
 - e. Any and all records which reflect or are related to a diagnosis of any tendon condition or injury, including tendonitis, tenosynovitis, tendonopathy, and tendon rupture or any allegedly related conditions.

- f. All documents in your possession, custody or control, concerning or relating to Levaquin® and/or all defendants in this lawsuit.
- g. All documents in your possession, custody or control, concerning or relating to tendonitis, tenosynovitis, tendonopathy, and tendon rupture or any allegedly related conditions.
- h. All documents in your possession, custody or control which were provided to you by any of the parties you have sued, or any pharmacy that distributed Levaquin®.
- i. All documents constituting any communications or correspondence between you and any representative of the parties you have sued, or any pharmacy that distributed Levaquin®.
- j. All photographs, drawings, diaries, journals, calendars, notes, slides, videos, DVDs or any other media relating to your alleged injury(ies) or your life after your alleged injuries began.
- k. If you claim you have suffered a loss of earnings or earnings capacity, your federal tax returns for each of the last five (5) years or W-2s or other tax documents, such as 1099s, for each of the last five (5) years.
- l. Documents relating to any claim for damages, including, but not limited to, medical, hospital, pharmacy or other bills.
- m. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).
- n. Decedent's death certificate and autopsy report (if applicable).

X. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge upon information and belief, that I have supplied all the documents requested in part IX of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

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

Date:

Signature

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO: _____

RE:
DOB:
SSN:

This will authorize a representative of _____,
or their agents or representatives to obtain any and all information pertaining to my employment
including but not limited to, my personnel file, benefits file, payroll records, FMLA records, workers'
compensation, and any and all reports of medical examinations and/or medical history in your files,
and to make photocopies of all or any portion thereof.

A photostatic copy of this authorization shall be as valid and may be used and relied on with
the same force and effect as the signed original thereof.

Signed

Dated

TO: Social Security Administration; OEO FOIA Workgroup;

INFORMATION REQUEST

Name

DOB

SSN

I authorize the Social Security Administration to release information or records about me to:

NAME

ADDRESS

I want this information released because:

Litigation

(There may be a charge for releasing information)

Please release the following information:

- Social Security Number
- Identifying information (included data and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- Information about benefits/payments I received from _____ to _____
- Information about my Medicare claim/coverage from _____ to _____

(specify) _____

- Medical records
- _____ Record(s) from my file (specify) _____

_____ Other (specify) _____

I am the individual to whom the information/record applies or the parent or legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signature, names, and addresses of five people if signed by mark.)

Date: _____ Relationship: _____

AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

TO: Department of Labor and Industry

FROM: Name:
SSN:
DOB:

I hereby authorize _____,
or their agent or representative, to inspect, review and obtain copies of any and all injury reports,
notices, medical reports, payment records, statements, orders and all other documents contained
in all Workers' Compensation files relating to _____.

Dated: _____

**AUTHORIZATION FOR RELEASE OF MEDICAL
RECORDS PURSUANT TO 45 CFR 164.508 (HIPAA)**

TO:
NAME:
DOB:
SSN:

I, _____, authorize you to disclose and release the following protected health information for the **WRITTEN MEDICAL RECORDS**: any and all medical records, all inpatient and out patient charts and records, hospital charts and records, doctor and nurse notes, emergency room records, clinic notes, correspondence, memoranda, physical therapy and rehabilitation records, patient questionnaire forms, patient history forms, social service records, laboratory reports, diagnostic reports, any and all photographs. **DIAGNOSTIC TESTS OR IMAGING**: operative photographs, videotapes, transcripts/tracings, slides, x-ray films, audio tapes. **PATHOLOGY**: any and all pathology. **RADIOLOGY**: written or recorded results or reports of any genealogical, bone, joint, muscle, tissue, blood, heart, lungs, cartilage, ligaments, vertebral bodies, brain, and/or nervous system and any and all films, studies, tracings or the like, including, but not limited to x-rays, MRI films, CAT scans, brain scans, bone scans, and EKG and EMG tracings in all forms. **PRESCRIPTION RECORDS**: any and all prescription records, the issuance of sale of prescription drugs, original doctor's prescription forms, refill records and pharmacy records. **PROTOCOL**: any and all documents describing the protocol and criteria for administration and interpretation of diagnostic tests or imaging. **BILLING**: any and all billing records, including itemized statements of charges, payments, all insurance records, including all claims, claim forms, correspondence, payments and reports.

Also, please disclose and release the following protected health care information (only if checked below):

| | |
|-------------------------------------|--------------------------|
| <input checked="" type="checkbox"/> | Drug and Alcohol Records |
| <input type="checkbox"/> | HIV and AIDS Records |
| <input checked="" type="checkbox"/> | Mental Health Records |

This protected health information is disclosed for the following purposes: Personal Injury/product liability lawsuit.

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

Name of Representative(s)

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

Street Address

City, State and Zip Code

This authorization shall be in force and effect until one year from the date signed below, at which time this authorization expires. I have the right to revoke this authorization, in writing, by sending written notification to you. I understand that a revocation is not effective to the extent that you have relied on my authorization to disclose protected health information. A photostatic copy of this authorization shall be valid and may be used and relied upon with the same force and effect as the signed original. I understand that the information may be redisclosed and no longer subject to protection. I understand that I have the right to:

- . Inspect or copy the individually identifiable health information to be disclosed and/or this authorization.
- . Refuse to sign this authorization, and that refusal to sign will not affect my right to continue to receive further care and

 treatment from the health care provider identified in this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

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