

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

In re: MEDTRONIC, INC,
IMPLANTABLE DEFIBRILLATORS
PRODUCTS LIABILITY LITIGATION

Multidistrict Litigation No.
05-1726 (JMR/AJB)

This Document Relates to All Actions

**ORDER REGARDING AUTHORIZATIONS
FOR RELEASE OF PLAINTIFFS' RECORDS**

In an effort to facilitate discovery in this MDL proceeding, and by agreement of Plaintiffs and Medtronic, Inc., the Court enters the following Order as to Authorization for Release of Plaintiffs' Records.

IT IS HEREBY ORDERED:

1. That Plaintiffs shall complete and sign the following Authorizations for the release of records pertaining to medical, insurance, employment, internal revenue service, social security, and, if applicable, workers compensation and social security disability, as provided in the Court approved Plaintiff Fact Sheet and which have been attached to the instant Order as follows:

Exhibit A: HIPAA Compliant Authorization for the Release of Medical
Records and Insurance Records, Pursuant to 45 C.F.R. 164.508;

Exhibit B: Request for Copy of Tax Returns for last five (5) years (IRS Form
4506);

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U.S. DISTRICT COURT MPLS

Exhibit C: Request for Social Security Earnings Information;

Exhibit D: Release of Employment and Unemployment Records;

Exhibit E: Worker's Compensation Authorization; and

Exhibit F: Consent for Release of Information Social Security Disability.

2. That the HIPAA Compliant Authorization for the Release of Medical Records and Insurance Records, Pursuant to 45 C.F.R. 164.508, the Release of Employment and Unemployment Records and the Worker's Compensation Authorization shall be subject to a 10-year limitation with the following qualifications:

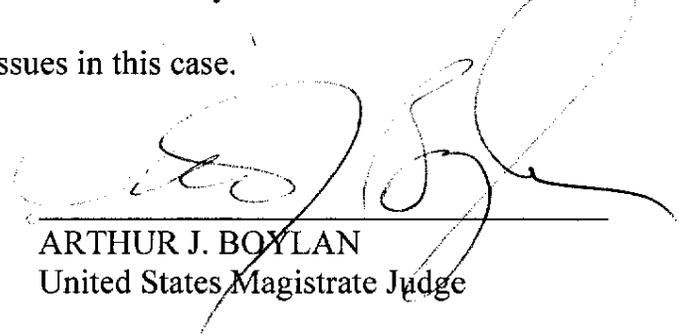
a. The parties shall be proactive in examining each Plaintiff's Fact Sheet so that in those situations where there is a reasonable basis for extending discovery beyond the 10-year period, that will occur without delay or Court involvement;

b. In cases where the Plaintiff consulted with a physician or other medical professional or healthcare provider regarding a cardiac (*i.e.*, ICD, CRT-D, or other cardiac-related device) implant or explant issue or any cardiac-related issue prior to the 10-year period, the 10-year limitation shall not apply; and

c. In cases where the information provided within the 10-year period makes it reasonably apparent that the mental, emotional, or physical health of the Plaintiff beyond the 10-year period will be probative of the issues in the case, the 10-year limitation shall not apply.

3. Plaintiffs and Medtronic, Inc. shall handle the issues noted above in a reasonable but expeditious manner so that all discovery timetables and deadlines are met, consistent with the scheduling orders issues in this case.

Date: February 21, 2007



A handwritten signature in black ink, appearing to read 'Arthur J. Boylan', is written over a horizontal line. The signature is stylized and cursive.

ARTHUR J. BOYLAN
United States Magistrate Judge

Exhibit A

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

In re: Medtronic, Inc., Implantable
Defibrillators Products Liability Litigation

MDL No. 05-1726 (JMR/AJB)

**HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS AND INSURANCE RECORDS**
Pursuant to 45 C.F.R. 164.508

To:

Health Care Provider/Covered Entity	

Patient Name	Social Security No.
_____	_____
Parents Name/Previous Name	Date of Birth
_____	_____
Address	

City, State and Zip Code	

I authorize the disclosure of all protected health care medical information in any form (including written and electronic). I expressly request that the health care provider or covered entity under HIPAA identified above disclose full and complete protected health information for the preceding ten (10) years from the date of this Authorization, including, but not limited to, the following:

- Provider's complete record (medical and otherwise) for the Patient;
- Any and all reports, notes, tests, test results, diagnoses, prognoses, office records and clinic records;
- Any inpatient, outpatient & emergency room treatment;
- All clinical charts, reports, documents, correspondence, statements, prescriptions, questionnaires/histories, office and doctor's handwritten notes, and records received from other physicians or health care providers;
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, MRA, echocardiogram, electrocardiograms, pulmonary function tests, stress tests, cardiac biopsies, angiograms, cardiac catheterization tapes, and cardiac catheterization reports;
- All radiology films, mammograms, myelograms, CT Scans, MRIs, MRAs, photographs, bone scans, pathology slides or evidence, cytology slides or evidence, histology slides or evidence, immuno-histo-chemistry specimens, autopsy slides, evidence or photographs, cardiac catheterization videos/CDs/films/reels; echocardiogram videos; echocardiograms and electrocardiogram tracings in all forms including original films, copy of computer storage of the data on disk or tape and a copy of the records;
- All cardiac event monitoring, ambulatory event monitoring and remote cardiac monitoring reports;
- All electrophysiology procedures and related reports;
- All pharmacy prescription records, including, but not limited to: NDC numbers and drug information handouts/monographs;
- All insurance information;
- Any and all surgical records, including but not limited to, surgical data, notes, documents, films, reports, logs, slips, operative notes, and correspondence;
- Any and all billing records, including but not limited to any and all bills from the Health Care Provider, any and all itemized billing statements, payment records, collection records, notes, memos, and correspondence; and
- All documents related to amendment of any record requested.

_____ (Initial) In addition to this required authorization for release of non-privileged protected health information, I also expressly authorize the release of privileged information, to the extent it is contained in the Patient's

Health Information and Records, such as regarding (check any if applicable): HIV/AIDS, mental health (including psychiatric and psychological testing) and/or alcohol/drug treatment.

I hereby authorize any physician, hospital, health care provider, pharmacy, insurance company, health facility/institution, governmental or private agency, and their respective agents, employees, or attorneys which maintain the Patient's Health Information and Records (collectively "Patient's Healthcare Providers") to make the uses and disclosures of the Patient's Health Information and Records specified in this Authorization.

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

Medical Research Consultants
6330 West Loop Road, Suite 105
Bellaire, Texas 77401

The Patient's Health Information and Records may be used by or disclosed to the attorneys, consultants, employees and other agents, including medical record collection companies of Greenberg Traurig, LLP and other counsel of record, who represent Medtronic, Inc. for the purpose of the above entitled matter ("the Litigation"), other counsel of record in the Litigation, and respective attorneys, consultants, agents, employees, contractors and experts in the Litigation (collectively "the Authorized Recipients"). I understand the Patient's Health Information and Records used or disclosed by the Patient's Healthcare Providers pursuant to this Authorization may be subject to redisclosure by the recipient, in which case they might no longer be protected under the HIPAA Privacy Rule and the HIPAA Privacy Rule may not apply to such redisclosure.

The purpose of the use or disclosure is to facilitate the investigation, evaluation, and defense of the claims and allegations set forth in the Litigation.

I understand that treatment, payment, enrollment or eligibility for benefits cannot be conditioned on whether or not I sign this Authorization.

I understand I may revoke (cancel) this Authorization by submitting a written revocation to Lori G. Cohen, Esq., Greenberg Traurig LLP, Suite 400-The Forum, 3290 Northside Parkway, Atlanta GA 30327. However, such revocation will not be effective with respect to any use or disclosure already made in reliance on this Authorization before such persons received notice of my revocation.

I hereby release the Patient's Healthcare Providers from any liability, damages and expenses arising in connection with the use or disclosure of the Patient's Health Information and Records pursuant to this Authorization.

This authorization expires at the close of litigation, including all appeals, for the Litigation 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 and agreed to by the undersigned that you are authorized to accept a facsimile, copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date: _____

Signature of Patient or Legal Representative

Relationship to Patient if not signed by Patient: _____
(Please provide Power of Attorney documents if Patient over the age of 18)

Exhibit B

Form **4506**

Request for Copy of Tax Return

(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

- ▶ Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.
- ▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0048

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a Tax Return Transcript for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

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

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

4 Previous address shown on the last return filed if different from line 3

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. The IRS has no control over what the third party does with the tax return.

Caution: If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.

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 year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

/ /	/ /	/ /	/ /
/ /	/ /	/ /	/ /

8 Fee. There is a \$39 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 or EIN and "Form 4506 request" on your check or money order.

a Cost for each return	\$ 39.00
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.

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, either husband or wife must sign. If signed by a corporate officer, partner, 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.

Signature (see instructions)	Telephone number of taxpayer on line 1a or 2a ()
Date	
Title (if line 1a above is a corporation, partnership, estate, or trust)	
Spouse's Signature	Date

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form. Use Form 4508 to request a copy of your tax return. You can also designate a third party to receive the tax return. See line 8.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4508-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Where to file. Attach payment and mail Form 4508 to the address below for the state you lived in when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

Note. If you are requesting more than one return and the chart below shows two different service centers, mail your request to the service center 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 the "Internal Revenue Service" at:
District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New York, Vermont	RAIVS Team 310 Lovell St. Stop G78 Andover, MA 01810
Alabama, Delaware, Florida, Georgia, North Carolina, Rhode Island, South Carolina, Virginia	RAIVS Team 4000 Buford Hwy. Stop 91 Chamblee, GA 30341
Arkansas, Kansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, Texas, West Virginia	RAIVS Team 3851 South Interregional Hwy. Stop 6710 AJ6C Austin, TX 78741
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nebraska, Nevada, New Mexico, Oregon, South Dakota, Utah, Washington, Wyoming	RAIVS Team 5048 E. Butler Ave. Stop 38101 Fresno, CA 93727
Connecticut, Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, North Dakota, Ohio, Wisconsin	RAIVS Team 2308 E. Bascom Road Stop 6708-B41 Kansas City, MO 64139
New Jersey, Pennsylvania, or foreign country, or A.P.C. or F.P.C. address	RAIVS Team DP 1365E Philadelphia, PA 19255-0885

Chart for all other returns

If you lived in or your business was in:	Mail to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, Wyoming	RAIVS Team P.O. Box 6441 Mail Stop 0734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 146600 Stop 2800 F Cincinnati, OH 45250
A foreign country, or A.P.C. or F.P.C. address	RAIVS Team DP 1365E Philadelphia, PA 19255-0885

All others: See section 6103(a) 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.

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 4508 for a taxpayer only if the authority has been specifically delegated to the representative on Form 2848, line 6. Form 2848 showing the delegation must be attached to Form 4508.

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. 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, and the District of Columbia 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 4508 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 4508 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:WICAR:MP:TT:SP, 1111 Constitution Ave. NW, IR-8406, Washington, DC 20224. Do not send the form to this address. Instead, see **Where to file** on this page.

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Signature and date. Form 4508 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 8 requesting the return be sent to a third party, the IRS must receive Form 4508 within 90 days of the date signed by the taxpayer or it will be rejected.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4508 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4508 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.

Partnerships. Generally, Form 4508 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

Exhibit C

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings

Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Earnings and Benefit Estimate Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.**PAPERWORK REDUCTION ACT:** This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.**INFORMATION ABOUT YOUR REQUEST****• How Do I Get This Information?**

You need to complete the attached form to tell us what information you want.

• Can I Get This Information For Someone Else?

Yes, if you have their written permission. For more information, see page 3.

• Who Can Sign On Behalf Of The Individual?

The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

• Is There A Fee For This Information?**1. Certified/Non-Certified Detailed Earnings Information**

Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us

and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

We will certify the detailed earnings information for an additional fee of \$15.00. Certification is usually not necessary unless you plan to use the information in court.

2. Certified Yearly Total of Earnings

Yes, there is a fee of \$15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.

3. Method of Payment

Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____	Social Security Number _____
Other Name(s) Used (Include Maiden Name) _____	Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

Detailed Earnings Information For the period(s)/year(s): _____
 (If you check this block, tell us below why you need this information.)

Certified Total Earnings For Each Year. For the year(s): _____
 (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement)

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 A. \$ _____

Do you want us to certify the information? Yes No

If yes, enter \$15.00 B. \$ _____

ADD the amounts on lines A and B, and enter the TOTAL amount C. \$ _____

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____

Daytime Phone Number _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name _____ Address _____

City, State & Zip Code _____

6. Mail Completed Form(s) To: **Exception: If using private contractor (e.g., FedEx) to mail form(s), use:**

Social Security Administration Division of Earnings Record Operations P.O. Box 33003 Baltimore Maryland 21290-3003	Social Security Administration Division of Earnings Record Operations 300 N. Greene St. Baltimore Maryland 21290-0300
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REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.
2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	\$15.00	15	\$43.75	28	\$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

• Whose Earnings Can Be Requested

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order.

Please fill in all the information below and return this form along with your request to:

Social Security Administration
 Division of Earnings Record Operations
 P.O. Box 33003
 Baltimore Maryland 21290-3003

Exception:

If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
 Division of Earnings Record Operations
 300 N. Greene St.
 Baltimore Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

CHECK ONE _____	<input type="checkbox"/> Visa <input type="checkbox"/> American <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Diners Card
Credit Card Holder's Name _____ (Enter the name from the credit card)	_____ <small>First Name, Middle Initial, Last Name</small>
Credit Card Holder's Address _____	_____ <small>Number & Street</small>
	_____ <small>City, State, & Zip Code</small>
Daytime Telephone Number _____	_____ <small>Area Code</small> _____ <small>Telephone Number</small>
Credit Card Number _____	_____ -- _____ -- _____
Credit Card Expiration Date _____	_____ <small>Month</small> _____ <small>Year</small>
Amount Charged _____	_____
Credit Card Holder's Signature _____	_____
DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization
	Name _____ Date _____
	Remittance Control # _____

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.

Exhibit D

**UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA**

In re: Medtronic, Inc., Implantable
Defibrillators Products Liability Litigation

MDL No. 05-1726 (JMR/AJB)

**AUTHORIZATION FOR RELEASE OF EMPLOYMENT
AND UNEMPLOYMENT RECORDS**

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish 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, psychiatric, nurse and dental records, x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to my employment with the above named institution, including records for treatment of psychological or psychiatric problems (only as specifically authorized below) concerning

Name of Employee

whose date of birth is _____ and

whose social security number is _____.

_____ (Initial) In addition to this authorization for release of employment and unemployment records, I also expressly authorize the release of privileged information, to the extent it is contained in my records, such as (check if applicable): HIV/AIDS, mental health (including psychiatric and psychological testing) and/or alcohol/drug treatment.

You are authorized to release the above employment 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.

Medical Research Consultants

Name of Representative

Record Collection Agency

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

6330 West Loop Road, Suite 105

Street Address

Bellaire, Texas 77401

City, State and Zip Code

The employment records may be used by or disclosed to the attorneys, consultants, employees and other agents of Greenberg Traurig LLP and other counsel of record, who represent Medtronic, Inc., in the above entitled matter (the "Litigation"), other counsel of record in the Litigation, and respective attorneys, consultants, agents, employees, contractors and experts in the Litigation.

The purpose of this disclosure is to evaluate, and to present evidence concerning, the claims and injuries asserted in the Litigation, including discovery, expert witness review, analysis of alleged damages, and for any and all other uses in connection with the Litigation.

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requester named above has executed the acknowledgement at the bottom of this authorization.

This authorization expires at the close of litigation, including all appeals, for the Litigation 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 and you are authorized to accept a facsimile, copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date: _____

Claimant or Guardian Signature

Date: _____

Witness Signature

Exhibit E

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

In re: Medtronic, Inc., Implantable
Defibrillators Products Liability Litigation

MDL No. 05-1726 (JMR/AJB)

AUTHORIZATION FOR RELEASE OF
WORKERS' COMPENSATION RECORDS

To:

Name

Address

City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort, including but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents; all medical records of any kind including psychological or psychiatric records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to any workers' compensation claims made, including any related to treatment of psychological or psychiatric problems (only as specifically authorized below) concerning

Name of Claimant

whose date of birth is _____ and

whose social security number is _____.

_____ (Initial) In addition to this required authorization for release of non-privileged protected health information, I also expressly authorize the release of privileged information, to the extent it is contained in the Patient's Health Information and Records, such as regarding (check any if applicable): HIV/AIDS, mental health (including psychiatric and psychological testing) and/or alcohol/drug treatment.

You are authorized to release the above workers' compensation 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.

Medical Research Consultants

Name of Representative

Record Collection Agency

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

6330 West Loop Road, Suite 105

Street Address

Bellaire, Texas 77401

City, State and Zip Code

The workers' compensation records may be used by or disclosed to the attorneys, consultants, employees and other agents of Greenberg Traurig LLP and other counsel of record, who represent Medtronic, Inc., in the above entitled matter (the "Litigation"), other counsel of record in the Litigation, and respective attorneys, consultants, agents, employees, contractors and experts in the Litigation.

The purpose of this disclosure is to evaluate, and to present evidence concerning, the claims and injuries asserted in the Litigation, including discovery, expert witness review, analysis of alleged damages, and for any and all other uses in connection with the Litigation.

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requester named above has executed the acknowledgement at the bottom of this authorization.

This authorization expires at the close of litigation, including all appeals, for the Litigation 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 and you are authorized to accept a facsimile, copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date: _____

Claimant or Guardian Signature

Date: _____

Witness Signature

atl-fs1\592062v06

Exhibit F

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- nonmedical records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the nonmedical information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PAPERWORK REDUCTION ACT: Paperwork Reduction Act Statement: This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. The office is listed under U. S. Government agencies in your telephone directory or you may call 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number
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I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

- _____ Social Security Number
- _____ Identifying information (includes date 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 that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____

(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____