HIPAA COMPLIANT AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

(No Psychological Injury is Claimed)

Person/Entity from Whom Records are Requested: _____
Provider Name ("Provider")

_____
Address City, State and Zip Code

Patient: _____
Patient Name

_____
Address City, State and Zip Code

_____
Date of Birth Social Security Number

Information Authorized To Be Disclosed: I authorize the Provider to furnish copies of my entire medical record and all of my individually identifiable health information, including, without limitation:

- medical reports
- CT scans
- MRA films
- prescription records
- employment records
- medical bills
- blood tests
- X-rays
- correspondence
- echocardiographic recordings
- wage records
- pathology specimens
- radiographic films
- MRI films
- progress notes
- written statements
- disability records

and other documents in your possession including records from other providers, except for records for treatment of psychological, psychiatric or emotional problems, to the following representative of the defendants in the litigation captioned *In re: Baycol Products Litigation*, MDL No. 1431 (D. Minn.), in which I am a plaintiff:

Person To Whom Records Are To Be Disclosed:

_____
Name of Representative ("Requestor")

_____
Representative Capacity

_____
Address City, State and Zip Code

The records requester has agreed to pay reasonable charges made by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting this disclosure to allow these records to be used in connection with the litigation in which I am a plaintiff.

Acknowledgements:

I understand that this disclosure may include information relating to treatment of drug or alcohol abuse, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases, sickle cell anemia treatment, tuberculosis information, and genetic testing information.

I understand that if the persons or entities to whom I am asking that the Provider disclose this information are not covered by federal privacy regulations, then this information will no longer be protected under federal privacy law and could be subject to re-disclosure.

I understand that my signing or revocation of this authorization will not affect my health care treatment or eligibility for payment under my health plan.

Term and Revocation: This authorization shall be considered as continuing in nature until a final, non-appealable judgment has been entered in the case I have brought. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Requestor any additional records created or obtained by the Provider after the date hereof. I understand that I may revoke this authorization at any time by writing to the Provider at the Provider's above address, but my revocation will not apply to information that has already been released before the Provider receives notice of any revocation.

It is expressly understood by me that the Provider is authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to the Provider.

Date: _____ _____
Signature of Patient or Personal Representative

Date: _____ _____
Witness Signature

This authorization is not valid unless the records Requester named above has executed the following acknowledgement:

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact Sheet; or, if the authorization is addressed to a third party not listed in Plaintiff's Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

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