HIPAA AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

   NAME OF PERSON OR FACILITY:

   _____

   ADDRESS:

   _____

   _____

2. The following person or class of persons may receive disclosure of protected health information about me:

   McGuireWoods LLP
   One James Center
   901 East Cary Street
   Richmond, VA 23229

3. The specific information that should be disclosed is: All medical or psychological or counseling records, x-rays, diagnostic studies, laboratory slides, documents, reports, clinical abstracts, histories, intake forms, charts, billing records, information or opinions, which they may request relative to my past, present or future physical condition, treatment, care and/or hospitalizations and to allow them to procure or copy whatever medical records, x-rays, slides or other information you have. I understand that I am authorizing the release of medical records which may contain information relating to the results of blood testing, including results of HIV testing.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying _____ **[Name of Person or Facility listed above]** in writing of my desire to revoke it.

However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on April 15, 2009.

_____
Name

_____
Date

_____
Date of Birth

_____
Social Security Number

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

I, _____, do hereby authorize my current and prior employers and their administrative staffs to release to any attorney or legal assistant of the law firm of McGuireWoods LLP all records of every nature pertinent in any way to my current or prior employment, including, but not limited to, the following:

1. Personnel records
2. Payroll records
3. Information regarding benefits
4. Evaluations
5. Complaints
6. Disciplinary information
7. Medical records
8. Workers' compensation documentation
9. Correspondence and notes

Charges for all copies of all records furnished shall be billed to McGuireWoods LLP, One James Center, 901 East Cary Street, Richmond, VA 23229.

A photocopy of the signed original of this Authorization shall be sufficient to authorize release of my records.

This Authorization shall not expire, and it shall remain valid absent express notification to the employer.

Date: _____

_____
Name

_____
Social Security Number

_____
Date of Birth

General Information

Court	United States District Court for the Northern District of Georgia; United States District Court for the Northern District of Georgia
Federal Nature of Suit	Personal Injury - Product Liability[365]
Docket Number	1:07-md-01845
Status	CLOSED