

# **EXHIBIT-A**

## **(Healthcare Authorization)**

**LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION  
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)**

TO: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize you to release and furnish to: **Sidley Austin/Eckert Seamans/Williams & Connolly/Litigation Management Inc. COPIES ONLY** of the following information:

- \* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- \* All reports of autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- \* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- \* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- \* All billing records including all statements, itemized bills, and insurance records.

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants and has been approved by the Court supervising this litigation. This authorization is for the sole purpose of allowing copies of my medical records to be provided to the defendants in this litigation. It does not allow discussions of my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition.
2. I understand that the information in my health 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. I understand that I have the 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 health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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 will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.
5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: \_\_\_\_\_ (plaintiff/representative)

Signature: \_\_\_\_\_

Date

## General Information

<b>Court</b>	United States District Court for the Southern District of Illinois; United States District Court for the Southern District of Illinois
<b>Federal Nature of Suit</b>	Personal Injury - Product Liability[365]
<b>Docket Number</b>	3:09-md-02100