AUTHORIZATION FOR THE RELEASE OF MENTAL HEALTH RECORDS PURSUANT TO 45 CFR 164.508(a) (2) (HIPAA)

TO:

Name of Mental Healthcare Provider/Physician/Facility

Address (Street, City, State, Zip Code)

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

 Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_ --\_\_\_\_--\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize you to release and furnish to:

 [INSERT DEFENSE COUNSEL]

and/or her/his/their designated agent, [insert agent, if any] copies of full and complete protected medical and mental health information, including the following:

For use in the In Re Testosterone Therapy Replacement Products Liability Litigation, MDL 2545. *To my healthcare provider: This authorization is forwarded by attorneys for defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me ,· it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me, unless you receive a separate and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the records, or any other matter bearing* *on my medical or physical condition at a deposition or trial.*

• All psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected medical and mental information including the following:

o All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, records received by other physicians, pharmacy and prescription records, billing records and records of billing to third party payers and payment or denial of benefits.

This protected health information is disclosed for the following purposes: The currently pending litigation involving the person named above.

This authorization is given in compliance with 42 CPR 2.3 1, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the representatives of defendants noted above who have agreed to pay reasonable charges made by you to supply copies of such records.

I acknowledge that I have the right to revoke this authorization by written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to

redisclosure by the recipient and no longer be protected under 45 CPR 164.508.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

I understand that the nature of this authorization is to authorize the release of my mental health records.

**A notarized signature is not required.** CFR 164.508. A facsimile, copy or photocopy of this Authorization shall have the same force as an original. *Unless otherwise revoked, this authorization shall expire at the conclusion of my involvement in the captioned litigation.*

I have read the above and authorize the disclosure of the protected mental health information as stated.

 Print Name:\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_