AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____[Plaintiff/Injured Party Name]. whether created before or after the date of signature. Records requested may include, but are not limited to:

> all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____] (date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original employment records. Please take all steps that are necessary to preserve the employment records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in *In Re Hair Relaxer*, MDL No. 3060 (N.D. Il.), including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE INSURANCE INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing insurance information, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name],** whether created before or after the date of signature. Records requested may include, but are not limited to:

> applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original insurance records. Please take all steps that are necessary to preserve the insurance records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all medical records, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested include, but are not limited to:

> all medical records, physician's records, surgeon's records, pathology/cytology reports, pathology/cytology specimens, slides, wet tissue, tissue blocks, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, prescription profile records, prescription slips, medication records, orders for medication, payment records, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, orders for medications, therapists' notes, social worker's records, insurance records, treatment pre-certifications, consent for treatment, statements of account, itemized bills, payment records invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original medical records, radiology, pathology/cytology slides, tissue/cell blocks, and any recut slides that are in your possession, as an expert may need to examine these slides and blocks in the future. Please take all steps that are necessary to preserve the medical records, radiology films, slides and blocks, and any recut slides that remain in your possession.

This authorization also includes the authority to permit agents or designees of **BrownGreer/MRC** to inspect and copy any and all such records.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE PSYCHIATRIC RECORDS AND PSYCHOTHERAPY NOTES INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all psychiatric records and psychotherapy notes records, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested may include, but are not limited to:

> complete copies of all psychiatric records and psychotherapy notes reports, therapist's notes, social worker's records, all medical records, physicians' records, surgeons' records, pathology/cytology reports, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, records of drug abuse and alcohol abuse, physicals and histories, nurses' notes, correspondence, insurance records, consent for treatment, statements of account, itemized bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning the physical or mental condition of this patient, or documents containing information regarding amendment of protected health information (PHI) in the medical records. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____] (date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original medical records, radiology, pathology/cytology slides, tissue/cell blocks, and any recut slides that are in your possession, as an expert may need to examine these slides and blocks in the future. Please take all steps that are necessary to preserve the medical records, radiology films, slides and blocks, and any recut slides that remain in your possession.

I do not authorize any ex parte verbal/oral communication concerning the subject mater of this authorization.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose my PHI, including psychiatric records and psychotherapy notes records and information, to **BrownGreer/MRC**. I further understand that records pertaining to psychiatric records and psychotherapy notes information may be specifically protected by federal and/or state regulations; by signing this authorization I am allowing the disclosure of any psychiatric records and psychotherapy notes information held by the entity identified above.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all psychiatric records and psychotherapy notes, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested may include, but are not limited to:

> complete copies of all psychiatric records and psychotherapy notes as defined by HIPAA 45 C.F.R. 164.501: psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original medical records, radiology, pathology/cytology slides, tissue/cell blocks, and any recut slides that are in your possession, as an expert may need to examine these slides and blocks in the future. Please take all steps that are necessary to preserve the medical records, radiology films, slides and blocks, and any recut slides that remain in your possession.

I do not authorize any ex parte verbal/oral communication concerning the subject mater of this authorization.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose my PHI, including psychiatric records and psychotherapy notes, to **BrownGreer/MRC**. I further understand that records pertaining to the psychiatric records and psychotherapy notes may be specifically protected by federal and/or state regulations; by signing this authorization I am allowing the disclosure of any psychiatric records and psychotherapy notes held by the entity identified above.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE TAX RETURNS INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing Tax information, regarding **_____[Plaintiff/Injured Party Name],** whether created before or after the date of signature. Records requested may include, but are not limited to:

> all tax returns, attachments to tax returns, forms, schedules, correspondence, and any statements, communications, reports, questionnaires, and records submitted, and any and all other documents and writings of any kind for the time period of 10 years prior to [_____](date of alleged injury) to the present.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above firms. A copy of this authorization may be used in place of and with the same force and effect as the original. This authorization expires one year after it is signed.

_____
Injured Party/Plaintiff or Personal Representative

_____
Date

_____
Name

_____
Former/Alias/Maiden Name

_____
Date of Birth Date of Death

_____
Social Security Number

_____
Address

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original workers' compensation records. Please take all steps that are necessary to preserve the workers' compensation records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address