

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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IN RE: NEW YORK BEXTRA AND CELEBREX : :
PRODUCT LIABILITY LITIGATION : :
: :
: :
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THIS DOCUMENT APPLIES TO ALL CASES
: :
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Index No. 560001/2005

CASE MANAGEMENT
ORDER NO. 7

FILED
AUG 02 2005
COUNTY CLERK'S OFFICE
NEW YORK

Authorizations For Release Of Medical And Other Records

Pursuant to Section II, paragraphs 2 through 6 of Case Management Order No. 6, Plaintiffs' Liaison Counsel and Defendants' Liaison Counsel have met and conferred regarding authorizations for the release of medical and other records. Liaison Counsel have also obtained the custodian-specific authorizations referenced in Section II, paragraph 3, subparagraph c of that Order. Attached hereto are the following authorizations:

<u>Attachment</u>	<u>Authorization</u>
A	Authorization for the Release of Medical Records (No Psychological Injury Asserted)
B	Authorization for the Release of Medical Records (Psychological Injury Asserted)
C	Authorization for the Release of Employment Records (No Wage Loss Asserted)
D	Authorization for the Release of Employment Records (Wage Loss Asserted)
E	U.S. Social Security Administration – Form for Requesting Social Security Earnings Records

<u>Attachment</u>	<u>Authorization</u>
F	U.S. Social Security Administration – Form for Requesting Social Security Disability Records
G	Albertson’s Pharmacy
H	Caremark Pharmacy
I	CVS Pharmacy
J	Target Pharmacy
K	Walgreen’s Pharmacy
L	Wal-Mart Pharmacy

FILED
 JUL 21 2006
 COUNTY CLERK'S OFFICE
 NEW YORK

The above authorizations are issued pursuant to Section II, paragraph 3 of Case Management Order No. 6.

SO ORDERED.

Dated: 7/31, 2006

SHIRLEY WERNER KORNREICH
 J.S.C.
 Hon. Shirley W. Kornreich, J.S.C.

A

SUPREME COURT OF THE STATE OF NEW YORK
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Name: _____

Date of Birth: _____

Social Security Number: _____

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

(No Psychological Injury Claimed)

This authorization does NOT authorize the release of records related to treatment of psychological, psychiatric, or emotional problems or records of abortion. DO NOT RELEASE such records.

**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

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, to include but not be limited to: x-ray reports, CT scan reports, echocardiographic recordings, radiographic films, blood tests, MRI scans, MRA films, EEGs, EKGs, sonograms, arteriograms, pathology specimens, discharge summaries, photographs, videos, DVDs, emails, or other electronically stored information, data, or images, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes, medical reports and records, progress notes, prescriptions, medical bills, invoices, histories, diagnoses, narratives, correspondence, memoranda, and billing information, pharmacy/prescription records including NDC numbers and drug information handouts/monographs, except for records related to treatment of psychological, psychiatric, or emotional problems. If the Provider is in possession of records from any other source, I authorize release of those records under this authorization.

This authorization does NOT authorize the release of records related to treatment of psychological, psychiatric, or emotional problems or records of abortion. DO NOT RELEASE such records.

This authorization also includes, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

Person to Whom Records are to be Disclosed ("Recipient"): I authorize disclosure of the above specified information to the defendant in the litigation captioned *In re Bextra and Celebrex Product Liability Litigation*, Index No. 560001/2005 in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants – Attn: RECORD RETRIEVAL

Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc.

Relationship to Recipient

6330 West Loop South, Suite 105

Address

Bellaire, TX 77401

City, State and Zip Code

I further authorize disclosure to any other counsel of record for Pfizer Inc. in the above captioned litigation that may be named in the future. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

Acknowledgements:

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for (please initial):

- _____ Drug or alcohol abuse
- _____ Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other sexually transmitted diseases
- _____ Sickle Cell Anemia
- _____ Tuberculosis
- _____ Genetic testing and counseling

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

Term: This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

Revocation: 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. Cancellation, revocation, or modification will only be valid once the Provider receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to Loren H. Brown, Esq., Raymond M. Williams, Esq., Attn. Bextra/Celebrex – NY COORD. PROC., DLA PIPER RUDNICK GRAY CARY US LLP, 1251 Avenue of the Americas, New York, New York 10020. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

Copies: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date: _____

Signature of Patient or Legal/Personal Representative

Description of Representative's Authority to Act for Patient, if Applicable

FOR MRC USE ONLY –

Plaintiff's Lawyer(s) to Receive Notices of Receipt of Requests and Records:

Lawyer's Name(s): _____

Firm Name: _____

Lawyer's Email(s): _____

(Required) _____

B

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Name: _____
Date of Birth: _____
Social Security Number: _____

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

(Psychological Injury Claimed)

This authorization does NOT authorize the release of records of abortion. DO NOT RELEASE such records.

**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

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, to include but not be limited to: x-ray reports, CT scan reports, echocardiographic recordings, radiographic films, blood tests, MRI scans, MRA films, EEGs, EKGs, sonograms, arteriogram, pathology specimens, discharge summaries, photographs, videos, DVDs, emails, or other electronically stored information, data, or images, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes, progress notes, prescriptions, medical bills, medical reports and records, invoices, histories, diagnoses, narratives, correspondence, memoranda, and billing information, pharmacy/prescription records including NDC numbers and drug information handouts/monographs. If the Provider is in possession of records from any other source, I authorize release of those records under this authorization.

This authorization includes records for treatment of psychological, psychiatric and emotional problems. It also includes, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

This authorization does NOT authorize the release of records of abortion. DO NOT RELEASE such records.

Person to Whom Records are to be Disclosed ("Recipient"): I authorize disclosure of the above specified information to the defendant in the litigation captioned *In re Bextra and Celebrex Product Liability Litigation*, Index. No. 560001/2005, in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants – Attn: RECORD RETRIEVAL

Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc.

Relationship to Recipient

6330 West Loop South, Suite 105

Bellaire, TX 77401

Address

City, State and Zip Code

I further authorize disclosure to any other counsel of record for Pfizer Inc. in the above captioned litigation that may be named in the future. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

Acknowledgements:

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for (please initial):

- _____ Drug or alcohol abuse
- _____ Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other sexually transmitted diseases
- _____ Sickle Cell Anemia
- _____ Tuberculosis
- _____ Genetic testing and counseling

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

Term: This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

Revocation: 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. Cancellation, revocation, or modification will only be valid once the Provider receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to Loren H. Brown, Esq., Raymond M. Williams, Esq., Attn. Bextra/Celebrex – NY COORD. PROC., DLA PIPER RUDNICK GRAY CARY US LLP, 1251 Avenue of the Americas, New York, New York 10020. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

Copies: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date: _____
Signature of Patient or Legal/Personal Representative

Description of Representative’s Authority to Act for Patient, if Applicable

FOR MRC USE ONLY –

Plaintiff’s Lawyer(s) to Receive Notices of Receipt of Requests and Records:

Lawyer’s Name(s): _____

Firm Name: _____

Lawyer’s Email(s): _____

(Required) _____

RECYCLED



C

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Name: _____
Date of Birth: _____
Social Security Number: _____

AUTHORIZATION FOR RELEASE OF RECORDS FROM EMPLOYER

(No Wage Loss Claimed)

This authorization does NOT authorize the release of records regarding the Employee’s pay, salary, income or other financial compensation, including, but not limited to, paychecks, paystubs and tax documents including W-4 and W-2 forms, or records of abortion. DO NOT RELEASE such records.

**Person/Entity from Whom
Records are Requested (“Provider”):**

Name of Employer/Educational Institution

Address City, State and Zip Code

Employee:

Employee Name (“Employee”)

Address City, State and Zip Code

Information Authorized To Be Disclosed: I authorize the Provider to furnish all records in its possession including but not limited to: the Employee's employment and education, copies of all applications for employment, resumes, records of all positions held, job descriptions of positions held, performance evaluations and reports, statements and comments of fellow employees, attendance records, all hospital, physician, clinic, infirmary, nurse and dental records, x-rays, test results, physician examination records, any records pertaining to claims made relating to health, disability or accidents in which the employee was involved including correspondence, reports, claim forms, questionnaires, medical reports, workers' compensation claims, and all other records relating to employment, past and present, and claims for disability. This listing is not meant to be exclusive.

This authorization does NOT authorize the release of records regarding the Employee's pay, salary, income or other financial compensation, including, but not limited to, paychecks, paystubs and tax documents including W-4 and W-2 forms, or records of abortion. DO NOT RELEASE such records.

Person to Whom Records are to be Disclosed ("Recipient"): I authorize disclosure of the above specified information to the defendant in the litigation captioned *In re Bextra and Celebrex Product Liability Litigation*, Index No. 560001/2005, in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants - Attn: RECORD RETRIEVAL

Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc.

Relationship to Recipient

6330 West Loop South, Suite 105

Address

Bellaire, TX 77401

City, State and Zip Code

I further authorize disclosure to any other counsel of record for Pfizer Inc. in the above captioned litigation that may be named in the future. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

Acknowledgements:

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

Term: This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

Revocation: I understand that I may revoke this authorization at any time by writing to the Employer at the Employer’s above address, but my revocation will not apply to information that has already been released before the Employer receives notice of any revocation. Cancellation, revocation, or modification will only be valid once the Employer receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to Loren H. Brown, Esq., Raymond M. Williams, Esq., Attn. Bextra/Celebrix - NY COORD. PROC., DLA PIPER RUDNICK GRAY CARY US LLP, 1251 Avenue of the Americas, New York, New York 10020. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

Copies: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date: _____

Signature of Employee or Legal/Personal
Representative

Description of Personal Representative's Authority to
Sign for Employee

FOR MRC USE ONLY –

Plaintiff's Lawyer(s) to Receive Notices of Receipt of Requests and Records:

Lawyer's Name(s): _____

Firm Name: _____

Lawyer's Email(s): _____

(Required) _____

D

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PRODUCT LIABILITY LITIGATION :
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-----X
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-----X

Name: _____
Date of Birth: _____
Social Security Number: _____

AUTHORIZATION FOR RELEASE OF RECORDS FROM EMPLOYER

(Wage Loss Claimed)

This authorization does NOT authorize the release of records of abortion. DO NOT RELEASE such records.

**Person/Entity from Whom
Records are Requested (“Provider”):**

Name of Employer/Educational Institution

Address City, State and Zip Code

Employee:

Employee Name (“Employee”)

Address City, State and Zip Code

Information Authorized To Be Disclosed: I authorize the Provider to furnish all records and information in its possession including but not limited to: Copies of all applications for employment, unemployment benefits, resumes, records of all positions held, job descriptions of positions held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, worker's compensation files, all health care records, including all hospital, physician, clinic, infirmary, nurse and dental records, x-rays, test results, physical examination records, any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to my employment with the above-named institution, including records regarding the Employee's employment, income, and education, including attendance reports, performance reports, W-4 and W-2 forms, medical reports, workers' compensation claims, and all other records relating to employment, past and present, and claims for disability. This listing is not meant to be exclusive.

This authorization does NOT authorize the release of records of abortion. DO NOT RELEASE such records.

Person to Whom Records are to be Disclosed ("Recipient"): I authorize disclosure of the above specified information to the defendant in the litigation captioned *In re Bextra and Celebrex Product Liability Litigation*, Index No. 560001/2005, in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants – Attn: RECORD RETRIEVAL
Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc.
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6330 West Loop South, Suite 105 Bellaire, TX 77401
Address City, State and Zip Code

I further authorize disclosure to any other counsel of record for Pfizer Inc. in the above captioned litigation that may be named in the future. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

Acknowledgements:

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

Term: This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

Revocation: I understand that I may revoke this authorization at any time by writing to the Employer at the Employer’s above address, but my revocation will not apply to information that has already been released before the Employer receives notice of any revocation. Cancellation, revocation, or modification will only be valid once the Employer receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to Loren H. Brown, Esq., Raymond M. Williams, Esq., Attn. Bextra/Celebrex – NY COORD. PROC., DLA PIPER RUDNICK GRAY CARY US LLP, 1251 Avenue of the Americas, New York, New York 10020. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

Copies: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date: _____

Signature of Employee or Legal/Personal
Representative

Description of Personal Representative's
Authority to Sign for Employee

FOR MRC USE ONLY –

Plaintiff's Lawyer(s) to Receive Notices of Receipt of Requests and Records:

Lawyer's Name(s): _____

Firm Name: _____

Lawyer's Email(s): _____

(Required) _____

E

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings

Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling
1-800-772-1213 to receive Form SSA-7004,
Request for Earnings and Benefit Estimate
Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.

INFORMATION ABOUT YOUR REQUEST

• How Do I Get This Information?

You need to complete the attached form to tell us what information you want.

• Can I Get This Information For Someone Else?

Yes, if you have their written permission. For more information, see page 3.

• Who Can Sign On Behalf Of The Individual?

The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

• Is There A Fee For This Information?

1. Certified/Non-Certified Detailed Earnings Information

Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us

and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

We will certify the detailed earnings information for an additional fee of \$15.00. Certification is usually not necessary unless you plan to use the information in court.

2. Certified Yearly Total of Earnings

Yes, there is a fee of \$15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.

3. Method of Payment

Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____	Social Security Number _____
Other Name(s) Used (Include Maiden Name) _____	Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

Detailed Earnings Information For the period(s)/year(s): _____
(If you check this block, tell us below why you need this information.)

Certified Total Earnings For Each Year. For the year(s): _____
(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement)

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 A. \$ _____

Do you want us to certify the information? Yes No

If yes, enter \$15.00 B. \$ _____

ADD the amounts on lines A and B, and enter the TOTAL amount C. \$ _____

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____

Daytime Phone Number _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name _____ Address _____
City, State & Zip Code _____

6. Mail Completed Form(s) To: **Exception:** If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.
2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	\$15.00	15	\$43.75	28	\$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

• **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

F

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

**When to Use
This Form**

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical records, should use this form.**
- **medical records, should not use this form, but should contact us.**

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

**How to
Complete
This Form**

This consent form must be completed and signed only by:

- **the person to whom the information or record applies, or**
- **the parent or legal guardian of a minor to whom the nonmedical information applies, or**
- **the legal guardian of a legally incompetent adult to whom the information applies.**

To complete this form:

- **Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.**
- **Fill in the name and address of the individual or group to which we will send the information.**
- **Fill in the reason you are requesting the information.**
- **Check the type(s) of information you want us to release.**
- **Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.**

PAPERWORK REDUCTION ACT: Paperwork Reduction Act Statement: This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. The office is listed under U. S. Government agencies in your telephone directory or you may call 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

6

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By my signature hereon, I authorize Albertsons, Inc., or any of its subsidiary companies or pharmacies, to release my protected health information as identified and in the manner and/or to the person(s) indicated below.

PHARMACY LOCATION: _____

PATIENT'S NAME: _____
(First) (M.I.) (Last)

PATIENT'S ADDRESS: _____

PATIENT'S DATE OF BIRTH: ____/____/____ PHOTO IDENTIFICATION NO. _____

PURPOSE OF DISCLOSURE:

- At the request of the patient.
- Other (provide explanation): _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

I AUTHORIZE THE FOLLOWING TO REQUEST PROTECTED HEALTH INFORMATION ON MY BEHALF:

I AUTHORIZE THE FOLLOWING TO RECEIVE THE PROTECTED HEALTH INFORMATION INDICATED ABOVE:

THIS AUTHORIZATION SHALL EXPIRE ON THE FOLLOWING DATE OR AT THE CONCLUSION OF THE FOLLOWING EVENT:

* I understand that my Authorization, or refusal to provide additional Authorization(s), does not affect my ability to obtain treatment from the pharmacy. I may revoke this Authorization in writing at any time by sending a letter to the pharmacy or by completing the pharmacy's Authorization Revocation Form, except to the extent that the pharmacy has taken action in reliance on this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA privacy regulations.

_____ I hereby represent and certify by my initials here and signature below that I am the patient identified above and that I give this Authorization of my own free will, am competent by law to give such Authorization, and will hold Albertsons and its affiliates and subsidiaries harmless from liability for their compliance with the provisions of this Authorization.

_____ I hereby represent and certify by my initials here and signature below that I am not the patient identified above, but provide this Authorization as a legal guardian, agent, representative, or executor of the patient or his/her estate. I represent by my signature below that I am legally or otherwise authorized to provide such Authorization on behalf of the patient. (Note: Proof evidencing legal authority is required.)

DATED: _____

SIGNED: _____
Patient or Authorized Representative



H

CAREMARK

It all starts with care.

Authorization for a one time release of personal health information

Requesting the records of the following Plan Participant:

Last Name: _____

First Name: _____ Middle Initial: _____

Previous Last Name (if applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ (mm/dd/yyyy) Phone Number: (____) _____

Caremark Plan Participant's Primary Cardholder Identification Number(s): _____

Name of Requestor (if different than above): _____

Relationship to Plan Participant:

Self

Parent

Legal guardian (Attach legal documentation)

Other: _____

(Attach legal documentation)

I hereby authorize Caremark to release the following information for the above-named Plan Participant:

Statement of Cost from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Prescription History from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Other health information, please specify:
_____ from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

This information should be released to: Check if same as address above.

Name: _____

Organization/Entity: _____

Address: _____

City/State/Zip: _____

The purpose of this authorization request is:

At request of plan participant

Required or requested by the recipient for purposes of _____

Other: _____

This Authorization will expire 90 days from the date of this authorization.

I understand that I have the right to revoke this Authorization at any time. This revocation will not affect any uses and/or disclosures already made based on this authorization before the revocation is received by Caremark. The revocation must be in writing and mailed to the address below. I understand that Caremark may not condition any treatment, payment, enrollment or my eligibility for benefits on my signing this Authorization. I understand that the information used and/or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the federal privacy law.

I certify that the foregoing information is true and correct.

Signature: _____ Date: _____

Print Name: _____

If signed by someone other than the above-named plan participant, please describe your legal authority to act on behalf of the participant and, if applicable, attach supporting documentation: _____

Witness Signature: _____

Witness Name: _____ Date: _____

Please Return Form To:
Caremark
P.O. Box 659529
San Antonio, TX 78265-9529

PEM2046-0403

I

5



AUTHORIZATION FOR RELEASE OF RECORDS

I authorize Target Pharmacy at my request to release my prescription profile to the individual identified below. I understand I can revoke this authorization at any time prior to its expiration, which unless otherwise indicated will be six (6) months from my execution of this authorization. In order to revoke this authorization, I must submit a written revocation to my local Target Pharmacy, and I understand that the revocation will be valid from the date received by the pharmacy, except to the extent the pharmacy has already taken action in reliance on this authorization. I understand that Target Pharmacy cannot refuse to fill my prescriptions based on whether I sign this authorization. I understand the information disclosed could be subject to redisclosure by the person receiving records as identified below, and no longer protected by federal privacy regulations. I have retained a copy of this authorization for my records.

Print Patient Name:

Date of Birth:

Dates of Records Request:

Start Date: _____ End Date: _____

Name and Mailing Address of Individual to Receive Records

Patient Signature:

Today's Date:

CERTIFICATION

If you are requesting records of another person who is unable to sign this authorization, complete the top part of this form with the information of the person whose records you are requesting. You must also certify your authority to act as follows:

I hereby certify that I am authorized to act for the individual whose records are to be released pursuant to this authorization. My authorization to act for this individual is derived from (check applicable statements):

- Health Care Power of Attorney
- Legal Guardian
- Personal Representative
- Other (describe): _____

Sign Your Name:

Today's Date:

Target reserves the right to exercise its discretion in releasing the records of any individual to you.

K



Return to: Walgreens Custodian of Records Department, 1901 East Voorhees Street,
PO Box 4039, MS #735, Danville, Illinois 61834

All sections must be filled in completely or the authorization is NOT valid!!



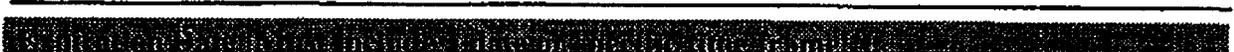
Your Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip _____
Telephone Number: _____



Name: _____
Address: _____
City, State, Zip: _____







This authorization expires *[specify date or event]*: _____



- You have the right to revoke this Authorization, in writing to Walgreens Custodian of Records Department, at any time. The revocation is only effective after it is received and logged by Walgreens. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.

- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative and include a description of that person's ability to act on behalf of the patient.

[REDACTED]

I, _____, by signing below, authorize Walgreens to use or disclose my protected health information as described above.

Signature

Date

[REDACTED]

RL

WAL*MART PHARMACY

WAL-MART PHARMACY AUTHORIZATION

Customer Release Of Protected Health Information

CUSTOMER INFORMATION

Customer (Person for whom request is made) _____
Customer's Date of Birth _____ Telephone Number _____
Customer's Address _____

AUTHORIZATION

I authorize the Pharmacy at location _____ and its business associates to release the Protected Health Information to the people, groups, or organizations that are listed below: *(Attach additional pages if necessary.)*

Name _____
Address _____

I authorize the Pharmacy to release my Protected Health Information from:

- Prescription _____
 Medical Expense Summary (listing of all prescription expenses).
 Designated Record Set (listing of all health information maintained by the pharmacy)
Date Range Requested From _____ To _____

REASON FOR REQUEST

You may check the box below that states "At customer's request" or you may specify below the reasons you are authorizing the Pharmacy to share your Protected Health Information.

- At the customer's request
 Other reasons (specify) _____

SIGNATURE

I understand that:

- This Authorization is valid for one (1) year from the date of my signature.
- I have the right to cancel this Authorization at anytime by completing a hard copy Cancellation of Authorization.

- If the Pharmacy has already released my health information that information will be exempt from my cancellation.
- If the person or entity that receives my health information is not required to comply with the federal privacy regulations, the information would no longer be protected by those regulations.

I understand that receipt of Pharmacy services is not contingent upon my signing this form. I understand that if I do not sign this form, the authorization will be invalid.

Customer's Signature _____ Date _____

If you have signed this form as a legally-recognized representative of the customer, please print your name below and your relationship to the customer that allows you to act on their behalf by signing this form.

Name of Representative (please print) _____ Relationship _____

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Pharmacy will obtain a valid, signed authorization from a customer prior to using or releasing the member's Protected Health Information, unless the customer's authorization is not legally required by law.

If you do not receive a response regarding this form within 45 days, you may assume that this request has been granted.

FOR PHARMACY USE ONLY:

Date Granted _____ Date Denied _____

HIPAA
BFOP-05A