

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

IN RE DIET DRUGS (Phentermine/ :
Fenfluramine/Dexfenfluramine) : MDL Docket No. 1203
PRODUCTS LIABILITY LITIGATION :

AUTHORIZATION

To: _____

Name

Address

City, State and Zip Code

This document authorizes you to disclose to the named party or parties below upon request, the following health information concerning _____, whose date of birth is _____ and whose social security number is _____, for the purpose of permitting defendants in my personal injury lawsuit access to medical information pertinent to that lawsuit. This authorization applies to the following records and information about them:

- All medical records, including but not limited to 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.
- All 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/tracings, and echocardiogram videotapes, CDs, and images of any kind.

- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

This authorization does not apply to psychotherapy notes. This authorization is not valid unless the requestor(s) named above have executed the acknowledgment at the bottom of this authorization. You may not condition treatment, payment, enrollment, or eligibility for benefits on whether this authorization is signed.

You are authorized to release the above information to the following representative of defendants in the above-entitled matter who has agreed to pay reasonable charges made by you to supply copies of records.

Name of Representative

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

* * *

This authorization may be revoked by writing to the individual to whom this authorization is provided. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions. 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.

I further acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by a recipient and not protected under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

This authorization expires two years from the date below.

Date: _____

Signature of Patient (or Patient’s Representative)

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

Date: _____

Witness Signature¹

ACKNOWLEDGMENT

The undersigned, as the requestor named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746 that the attorney for the patient named in the foregoing medical authorization has been given fifteen (15) days advance notice that the authorization will be used to request records from the person or entity to whom it is addressed and has been afforded an opportunity to object to the request for records and to order copies of the records requested from the undersigned requestor at a reasonable cost.

¹ This authorization must be signed and notarized by a notary public when required under applicable state law in order for this authorization to be valid.