UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

IN RE: PROTON-PUMP INHIBITOR PRODUCTS LIABILITY LITIGATION	**2:17-MD-2789 (CCC)(LDW) (MDL 2789) and all member and related cases**
This Document Relates to: All Actions	**Judge Claire C. Cecchi**

CASE MANAGEMENT ORDER NO. 80
(Wave Order #2)

As of August 15, 2022, there are approximately 13,400 cases pending in this MDL proceeding, *In re: Proton Pump Inhibitor Products Liability Litigation*. One group of bellwether cases has completed discovery, and three bellwether cases are set for trial. Twenty additional cases were selected for a second bellwether group and two hundred cases were selected for a first wave, and discovery is currently underway in those groups. The Court finds that case-specific discovery of additional cases is necessary to promote the just and efficient conduct of this litigation. Accordingly, the Court is hereby issuing this order relating to a second group of two hundred cases that will undergo case-specific discovery in preparation for trial. Subsequent wave orders will be issued.

I. Selection of Wave Two Cases

Wave Two shall consist of the 200 cases identified on Exhibit A hereto. These 200 cases consist of one case that is being removed from Wave One and 199 that were randomly selected from the group of cases that (a) were identified as Eligible Round 2 Cases pursuant to Paragraph I of Case Management Order ("CMO") No. 54, (b) were not on the final list of 24 cases selected pursuant to Paragraph II.A.3 of CMO No. 54, (c) were not in the group of 200 cases in Wave One pursuant to CMO No. 74, (d) were not subject to the show cause orders in CMO Nos. 58-66, and (e) were not subject to motions to dismiss pursuant to the briefing ordered under CMO Nos. 52 (Michigan) or 53 (Texas).[1]

II. Initial Showing

A. No later than thirty days after the issuance of this Order, counsel for each Plaintiff in Wave Two shall provide to counsel for all Defendants[2] pending in the case and to my office via email (at PPISpecialMaster@rkgattorneys.com) the following:

[1] Cases in subsequent waves may be selected from other groups of cases.

[2] For the purposes of this Order, each Defendant and its related entities will be treated as one Defendant. For example, Takeda Pharmaceuticals U.S.A., Inc. (TPUSA) and Takeda Pharmaceuticals America (TPA), Inc. are related entities and will be treated as one Defendant for purposes of this CMO.

1. A certification that Plaintiffs' counsel has spoken directly with the named Plaintiff[3] by telephone, by video conference, or in-person and confirmed that the Plaintiff is able to participate in the litigation and wishes to proceed with the lawsuit as to each and every Defendant pending in the case or, in the event the Plaintiff only wishes to proceed against some of the Defendants pending in the case, has authorized Plaintiffs' counsel to dismiss from the case any Defendants against whom the Plaintiff does not wish to proceed; and

2. Documentation that the Plaintiff[4] took a specific PPI product manufactured and sold by each Defendant pending in the case against whom the Plaintiff wishes to proceed. As to each PPI product, the documentation shall consist of one or more of the following (a) a medical record confirming that the Plaintiff took the PPI product in question, (b) a pharmacy record confirming purchase of the PPI product in question, (c) some other record

[3] If more than one Plaintiff (*e.g.*, both an individual who ingested the PPI product and a spouse) is named in a case, the Initial Showing in Section II.A.1 must be made as to the individual who ingested the PPI product (*e.g.*, not as to the spouse), or the person acting in a representative capacity for such individual (*e.g.*, a personal representative of the individual's estate).

[4] In the event that a Plaintiff in a Wave Two case is not the individual who ingested the PPI product (*e.g.*, a personal representative of an estate), the documentation of PPI usage in Section II.A.2 and the documentation of kidney injury in Section II.A.3 shall be as to the individual who ingested the PPI product.

confirming purchase of the over-the-counter PPI product in question, or (d) a declaration under penalty of perjury by the Plaintiff based on his or her personal knowledge containing specific information that would be admissible in evidence and about which the Plaintiff is competent to testify. Such declaration must include, at a minimum, the dates the PPI product in question was used; how, when, and from where the PPI product in question was purchased or obtained, including (where applicable) by whom it was prescribed; whether the PPI product was a branded or generic product; and any other specific information that the Plaintiff can provide (*e.g.*, description of the pill or packaging) to support the allegation that the Plaintiff used the PPI product in question;

3. Specific medical records demonstrating that the Plaintiff was diagnosed with or received treatment for a kidney injury following PPI ingestion or a declaration under penalty of perjury from a licensed physician attesting that such physician has diagnosed the Plaintiff with a kidney injury following PPI ingestion; and

4. Authorizations[5] duly executed by the Plaintiff as set forth below:

   a. The authorizations in the forms attached hereto as Exhibit B in an amount equal to one more than the number of health care providers identified in that Plaintiff's Plaintiff Fact Sheet ("PFS"), provided such authorizations provided to Defendants pursuant to this Order shall be signed without setting forth the identity of the applicable custodian of the records or provider of care;

   b. The proprietary authorizations for CVS Pharmacy, Walgreen's Pharmacy, Wal-Mart Pharmacy, Express Scripts Pharmacy, Humana Health Care Insurance Co., and Cigna Insurance Co. in the forms attached hereto as Exhibit C, but only as to the aforementioned entities which are actually identified in that Plaintiff's PFS; and

   c. The governmental authorizations in the forms attached hereto as Exhibit D, but only where applicable to the claims asserted in that case.

[5] To the extent Defendants wish to obtain records from a custodian of records who will not accept the authorizations in the form that Plaintiff executed pursuant to this Order or another CMO, or Defendants need additional authorizations to obtain records, Defendants shall notify that Plaintiff's counsel and provide the necessary authorizations to obtain the records. Plaintiff will cooperate with Defendants and provide the necessary authorization(s).

All authorizations provided to Defendants pursuant to this Order shall be signed without dating the authorizations.

B. If, within thirty days of the date this Order is entered, a Plaintiff fails to provide all such documentation required in Section II.A. as to:

1. all Defendants pending in the case, that case may not proceed in Wave Two. Unless that case is voluntarily dismissed, it shall be placed on an order to show cause why the case should not be dismissed without prejudice; or

2. some Defendants pending in the case, that case may proceed in Wave Two only as to the Defendants as to whom all such documentation has been provided. Unless the case is voluntarily dismissed as to those Defendants for whom the documentation required in Section II.A has not been provided, it shall be placed on an order to show cause why the case should not be dismissed as to those Defendants.

C. Special Master Reisman shall resolve any disputes about the sufficiency of the documentation provided pursuant to Section II.A.

III. Case-Specific Fact Discovery for Wave Two Cases

A. Between November 1, 2022 and June 30, 2023, case-specific fact discovery of the Wave Two Cases that have complied with Section II above shall take place.

B. The following limitations shall apply to case-specific fact discovery:[6]

1. Each Defendant is limited to 10 interrogatories, 10 requests for production of documents and 10 requests for admission per case.

2. Plaintiffs[7] are limited to 10 interrogatories, 10 requests for production of documents (including requests to produce sales representative custodial files) and 10 requests for admission to each Defendant.

3. In each individual case, each side will be entitled to take five fact witness discovery depositions, which is inclusive of plaintiff, treating and prescribing physicians, and sales representatives.[8]

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[6] Counsel for all parties should be mindful to avoid the inappropriate attempts in Wave One to circumvent the limits set forth herein on interrogatories, requests for production of documents, and requests for admission.

[7] If more than one Plaintiff (*e.g.*, both an individual who ingested the PPI product and a spouse) is named in a case, Plaintiffs are treated as one entity for purposes of these discovery limitations.

[8] To the extent disputes arise regarding the division of time between the parties for the deposition of treating physicians (three hours total absent agreement), such disputes should be referred to Special Master Reisman for decision.

4. The deposition of any fact witness is limited to 3 hours absent agreement of the parties.

C. Special Master Reisman will consider modifications to the above limitations only upon good cause shown and only if resolution cannot be reached after the parties meet and confer.

D. The following deadlines shall apply for completion of fact discovery for the Wave Two Cases:

Deadline to serve written discovery requests	December 14, 2022
Responses to written discovery due[9]	January 13, 2023
Completion of depositions and close of fact discovery	June 30, 2023

IV. Expert Discovery for Wave Two Cases

A. Between July 1, 2023 and January 31, 2024, expert discovery for the Wave Two Cases shall take place.

B. The following deadlines shall apply for expert discovery for the Wave Two Cases:

Plaintiffs' Expert Disclosures	August 8, 2023
Defendants' Expert Disclosures	October 2, 2023
Plaintiffs' expert witness rebuttal reports	October 27, 2023
Deposition deadline and close of expert discovery	January 31, 2024

[9] This deadline for completion of all responses to written discovery does not change the requirement that parties respond to written discovery requests within the thirty-day periods set forth in Rules 33, 34 and 36 of the Federal Rules of Civil Procedure. Rather, it is the last date on which responses to written discovery can be due without obtaining an extension of time from the Court.

C. Each expert witness disclosure shall include at least two dates when each expert is available for a deposition. Depositions can only commence after both sides' expert reports have been served.

D. Depositions of Plaintiffs' experts will be completed before depositions of Defendants' experts in the same discipline, absent agreement of the parties or permission from the Special Master.

E. The parties shall be required to coordinate the depositions of experts when they are utilized across multiple Wave Two Cases.

F. The following limitations shall apply to expert discovery:

1. Plaintiffs and each defendant are limited to no more than five experts per case (exclusive of treating physicians).

2. The deposition of any expert witness is limited to 7 hours absent agreement of the parties.

G. Special Master Reisman will consider modifications to the above limitations only upon good cause shown and only if resolution cannot be reached after the parties meet and confer.

V. Depositions for Wave Two Cases

A. The depositions of all Wave Two Cases shall be taken in accordance with the terms set forth in CMO Nos. 40 and 45, subject to the following changes:

1. Plaintiffs shall have priority in questioning prescribers, treaters, and other health care professionals in the Wave Two Cases designated by an odd number on Exhibit A.

2. Defendants shall have priority in questioning prescribers, treaters, and other health care professionals in the Wave Two Cases designated by an even number on Exhibit A.

B. Special Master Reisman will consider modifications in individual cases upon good cause shown and only if resolution cannot be reached after the parties meet and confer.

VI. Motions for Wave Two Cases

A. The following deadlines shall apply for summary judgment and *Daubert* briefing:

Filing of *Daubert* motions	March 1, 2024
Filing dispositive motions	March 15, 2024
Responses to *Daubert* motions	March 29, 2024
Responses to dispositive motions	April 12, 2024
Replies to *Daubert* motions	April 26, 2024
Replies to dispositive motions	May 10, 2024

B. If the Court determines that a hearing or oral argument on summary judgment and/or *Daubert* motions, or limited/certain parts thereof, is necessary, such a hearing may be scheduled by the Court for a date to be determined by the Court.

C. If discovery reveals facts that could a support a motion that would be dispositive of the *entirety* of a Plaintiff's claims against one or more named Defendants, either side may seek permission from Special Master Ellen Reisman in the individual case to file an early dispositive motion on that issue. If such leave is granted in an individual case, Special Master Reisman shall set a briefing schedule at that time.

VII. Cases Ready for Transfer or Remand

A. Venue recommendations. By no later than May 17, 2024, the parties to each Wave Two Case shall meet and confer concerning the appropriate venue for each case, and the parties shall submit joint venue recommendations to Special Master Reisman by May 31, 2024. The parties' joint recommendations shall identify the cases about which the recommended venue is in dispute. Special Master Reisman may then request briefing concerning those Wave Two Cases about which the parties disagree. Each party reserves the right to object to the venue selected by another party or the Court.

B. Upon completion of discovery and motions practice, the Wave Two Cases where venue in the United States District Court for the District of New Jersey

is not determined to be proper by the Court shall be transferred to a federal district court of proper venue pursuant to 28 U.S.C. §1404(a) (if directly-filed in this MDL), or remanded to the federal district court from which such case was initially transferred pursuant to 28 U.S.C. §1407. The trial date for such cases transferred or remanded to other federal district courts shall be set by the judge to whom the transferred or remanded case is assigned.

C. Upon completion of discovery and motions practice, for any Wave Two Case where venue in the United States District Court for the District of New Jersey is determined to be proper by the Court, the Court will set a trial date in a separate Order.

SO ORDERED

SIGNED on this 22nd day of August, 2022.

_____

ELLEN K. REISMAN

Special Master

Exhibit A

	Plaintiff Name	Case No.
1	Alaimo, John	2:18-cv-05261
2	Albert, Esparonza	2:19-cv-18227
3	Allen, Lester	2:18-cv-09291
4	Anderson, Darlene	2:18-cv-01013
5	Archer, Winford Henry	2:18-cv-03835
6	Bage, Beverly	2:18-cv-14808
7	Ballard, Sharon	2:18-cv-12337
8	Barr, Diane	2:19-cv-17455
9	Bellamy, Anita	2:17-cv-06093
10	Bennett, Thomas	2:20-cv-03207
11	Bookout, Gary	2:18-cv-05385
12	Boyer, Sallyann	2:18-cv-00443
13	Brandt, Jane E	2:18-cv-14854
14	Breaux, Willie Bell	2:18-cv-16756
15	Brewer, Robert Lee	2:19-cv-20767
16	Brocks, Estella	2:19-cv-13926
17	Brown, Geraldine C	2:18-cv-15015
18	Brown, Sherry	2:19-cv-12532
19	Brown, Stephen K.	2:18-cv-05233
20	Bruno, Fara	2:18-cv-04445
21	Bullard, Joyce LaPrade	2:19-cv-07408
22	Burke, William	2:18-cv-14020
23	Byerly, Paul, Jr.	2:18-cv-03533
24	Calabro, Linda	2:19-cv-18468
25	Callahan, Carolyn	2:18-cv-15423
26	Campbell, Robert	2:18-cv-03503
27	Campbell, Robin	2:18-cv-01623
28	Carini, Sandra Jane	2:19-cv-19633
29	Carmona, Debra A.	2:19-cv-01642
30	Carter, Pamela	2:19-cv-12026
31	Castro, Judy	2:18-cv-09252
32	Cognetti, Carmela	2:18-cv-11780
33	Combs, Caren	2:18-cv-00297
34	Comella, Cindy Ann	2:19-cv-21850
35	Connell, Vicki J	2:18-cv-10380
36	Corron, Pamela	2:18-cv-05778
37	Creasman, David Eugene	2:19-cv-12941
38	Crews, Carolyn	2:18-cv-11938
39	Cublinsky, David	2:19-cv-21113
40	Dailey, Sam	2:19-cv-10049
41	Dalton, Tracie	2:19-cv-16957
42	Dangler, Linda	2:19-cv-19521
43	Davenport, Jimmie	2:19-cv-01022
44	DeMaris, Sandra	2:20-cv-02435
45	Dineen, Frances	2:19-cv-10368
46	Dixson, Rena M.	2:18-cv-01663

Exhibit A

47	Dodd, Thomas	2:18-cv-02214
48	Donald, Karen B.	2:17-cv-05930
49	Dula, Jean	2:19-cv-14089
50	Dunn, Sandra	2:18-cv-03494
51	Dyal, George	2:18-cv-03570
52	Early, Margaret	2:19-cv-18405
53	Edwards, Rhonda K	2:19-cv-18507
54	Elliott, Janet L	2:18-cv-14856
55	Ernce, Nancy	2:19-cv-01298
56	Fackler, Rochelle	2:18-cv-03959
57	Fallucca, Virginia	2:18-cv-00063
58	Farrell, Annie M	2:19-cv-11643
59	Fernandes, Paul	2:18-cv-00275
60	Files, William D	2:19-cv-12688
61	Ford, Mary E	2:19-cv-17512
62	Fortney, Karen	2:18-cv-03154
63	Foster, Minnie Louise	2:20-cv-03548
64	Gallagher, Renate	2:18-cv-03050
65	Geer, James Wayne	2:20-cv-01102
66	Gelpi-Pages, Aida	2:19-cv-18460
67	Gibson, Sherrie	2:18-cv-03395
68	Gilmer, Vikki	2:19-cv-18572
69	Goldner, Andrew	2:18-cv-03799
70	Goodman, Josh Allen	2:18-cv-03754
71	Graham, Carrie Lee	2:19-cv-14783
72	Granderson, Wilber A.	2:19-cv-09333
73	Green, Tamara	2:19-cv-22039
74	Grilla, Michael Peter	2:19-cv-11624
75	Grubb, Julie	2:18-cv-11045
76	Hale, Janice	2:18-cv-09672
77	Hall, Elbert W.	2:17-cv-05953
78	Hancher, Regina	2:18-cv-05421
79	Hancock Thomas	2:18-cv-09970
80	Harris, Janet L	2:19-cv-01272
81	Hartman, Christine	2:18-cv-03074
82	Hicks, Patricia	2:19-cv-21636
83	Hinton, Elizabeth	2:19-cv-09893
84	Holliday, Hubert	2:18-cv-14238
85	Holmes, Christine	2:17-cv-12927
86	Honcharik, Cassandra	2:18-cv-01029
87	Howlett, Carol L	2:19-cv-17556
88	Jackson, Pierre R.	2:19-cv-11241
89	James, Calvin E	2:18-cv-09378
90	James, Wyonnie	2:19-cv-15335
91	Jenkins, Annie Braddy	2:18-cv-14310
92	Johnson, Andrew Martin	2:19-CV-02088
93	Johnson, Betty	2:18-cv-17377

Exhibit A

94	Johnson, Francis Robert	2:19-cv-21989
95	Jones, Sandra	2:18-cv-03833
96	Jones, Tinsley	2:18-cv-04277
97	Kennedy, Karin	2:17-cv-05911
98	Laing, Feona	2:18-cv-00330
99	Layne, Charles	2:19-cv-06000
100	Ledbetter, Richard Marion, Sr.	2:19-cv-01284
101	Leonard, John Darin	2:19-cv-18504
102	Leverette, Dorothy	2:18-cv-03010
103	Logan, Bruin	2:19-cv-10237
104	Long, Donell	2:17-cv-13290
105	Lusk, Aubrey Lewis	2:18-cv-05930
106	Lybarger, Sue	2:19-cv-16490
107	Maiers, Tina	2:18-cv-01783
108	Makkar, Apjeet	2:18-cv-00179
109	McGee, June Y	2:18-cv-03614
110	McGlothine, Michael Llyod	2:19-cv-18682
111	Means, Dolores	2:18-cv-03837
112	Mee, James	2:18-cv-01650
113	Melson, Tasha	2:19-cv-17829
114	Messer, Carolyn	2:18-cv-00317
115	Miller, Debbie	2:19-cv-14604
116	Miller, Mark	2:19-cv-16081
117	Mills, Robert	2:18-cv-05282
118	Minnie, Sandra	2:19-cv-18944
119	Montjoy, Connie	2:18-cv-03511
120	Munsey, Sandra	2:19-cv-14389
121	Murphy Brian N.	2:18-cv-08442
122	Murphy, Theresa	2:18-cv-04438
123	Neal, Doris V	2:19-cv-12696
124	Neblett, Geneva	2:19-cv-18591
125	Oliver, Helen	2:19-cv-00408
126	Olson, Mickey	2:18-cv-05257
127	Ortiz-Turner, Elva	2:20-cv-02689
128	Owsley Rosemary	2:20-cv-13185
129	Pack, William	2:18-cv-02289
130	Paniagua, Rosalinda	2:19-cv-01067
131	Parker, Scotty G	2:19-cv-05931
132	Payne, Linda	2:17-cv-07775
133	Polino, Leslie Joan	2:19-cv-11371
134	Priester, Carlos	2:18-cv-05742
135	Rankins, Hilda	2:19-cv-01133
136	Ray, Youlandia C., Sr.	2:19-cv-03254
137	Reeves, Bonnie	2:17-cv-04278
138	Reeves, Louella G	2:19-cv-18241
139	Ricks, Vernell	2:19-cv-03311
140	Riley, Gregory	2:17-cv-06223

Exhibit A

141	Robbins, James	2:19-cv-09378
142	Roberts, Ronald	2:18-cv-03649
143	Robinson Gonzalez, Michael D.	2:19-cv-20152
144	Robinson, Lee Allen	2:19-cv-13271
145	Robinson, Lynn	2:18-cv-03795
146	Ross, Jeremy M	2:19-cv-15625
147	Roy, Jean Marie	2:19-cv-11524
148	Russell, Deborah J.	2:18-cv-03496
149	Sanchez-Nieves, Noemi	2:19-cv-11066
150	Schnagl, Ann Louise	2:17-cv-13141
151	Schultz, Ronald Martin	2:19-cv-18977
152	Sears, Veola A	2:19-cv-13930
153	Serna, Cecilia Marie	2:19-cv-16454
154	Shaffer, David	2:18-cv-07882
155	Short, Donald	2:18-cv-03062
156	Simon, Josephine	2:18-cv-06718
157	Smith, Betty	2:19-cv-12875
158	Smith, Lorraine	2:20-cv-07291
159	Sosa, Ernest	2:19-cv-16471
160	Spann, Denise	2:19-cv-01405
161	Spann, Geraldine	2:19-cv-10320
162	Spiller, Pamela	2:18-cv-05766
163	Stafford, Mary S.	2:18-cv-07826
164	Starr, Carol	2:18-cv-03582
165	Stephens, Thelma	2:19-cv-07311
166	Stewart, Chloe	2:18-cv-03841
167	Stewart, Linda	2:18-cv-03158
168	Stisser, Lee Howard	2:20-cv-03995
169	Sullivan, Margaret	2:19-cv-11899
170	Swann, Donna	2:19-cv-08708
171	Tabor, Kimberly	2:19-cv-20627
172	Taylor, Debra A	2:18-cv-09120
173	Thacker, Brian	2:17-cv-05884
174	Thomas, Florean	2:18-cv-15898
175	Thomas, James Maxie	2:18-cv-17265
176	Thomas, Linda	2:18-cv-01048
177	Tomolonis, Dennis	2:18-cv-00770
178	Truett, Bobby G.	2:20-cv-04744
179	Tyndall, Iris	2:19-cv-17467
180	Van Kirk, William	2:18-cv-01664
181	Vashon, Steven Lawrence	2:19-cv-14239
182	Waldron, Sharon	2:18-cv-16764
183	Walker, Xavier	2:19-cv-01554
184	Waters, Lakisha	2:18-cv-03082
185	Watson, Herb	2:20-cv-07943
186	Watts, Anita	2:18-cv-11153
187	Webb, Terri	2:18-cv-14830

Exhibit A

188	White, Lisa Kay	2:18-cv-17722
189	White, Vivian A	2:19-cv-09633
190	Whitmore, Martha	2:18-cv-01661
191	Williams, James P	2:19-cv-09719
192	Willingham, Jimmie C.	2:17-cv-05975
193	Willis, Annie Louise	2:18-cv-05711
194	Windom, Patsy	2:19-cv-20496
195	Woller, Violet Faye	2:19-cv-07487
196	Woodruff, Stephen Samuel	2:20-cv-00548
197	Word, Lois	2:18-cv-14527
198	Yarde, Codrington Desideriu	2:17-cv-13797
199	Zamir, Jan	2:19-cv-02167
200	Zeidan, Sayel Raji	2:18-cv-15488

EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

To: _____
Name

_____
Address

_____
City, State and Zip Code

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

This will authorize you to furnish copies of the following records and/or information **from the time period of twenty (20) years prior to the date on which the authorization is signed**:

* 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 autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and 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.

****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501**.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial**.
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).
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 indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original.
6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040.

Date:_____ _____
Patient/Representative Signature *[Print name if not Patient]*

Date:_____ _____
Witness Signature

LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST

LIMITED AUTHORIZATION FOR RELEASE OF HEALTH INSURANCE RECORDS
(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all insurance claims applications and benefits, and all medical, health, hospital, physicians, nursing or allied health professional reports, records or notes, invoices and bills, in your possession that pertain to the named insured identified below. **This authorization only authorizes release of Health Insurance records and/or information from the time period of twenty (20) years prior to the date on which this authorization is signed**.

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

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040**.**

This authorization only authorizes release of documents and records from the period of twenty (20) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date:_____ _____
Insured/Guardian/Personal Representative
Signature *[Print name if not Insured]*

Date:_____ _____
Witness Signature

LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST

EXHIBIT C

CVS Pharmacy DISCLOSURE AUTHORIZATION FORM
One CVS Drive, Woonsocket, RI 02895
Fax (401) 652-1593

PATIENT REQUESTING DISCLOSURE

Name: _____
Address: _____
Address: _____
Date of Birth _____

I hereby authorize CVS Pharmacy to disclose my Patient Prescription Record (PPR), reflecting my prescription history and any other pharmacy services I have received from CVS Pharmacy as set forth below:

1. My Patient Prescription Record (PPR), may be disclosed to the following person(s) categories of person or entities:
   Name: The Marker Group, Inc.
   Address: 13105 Northwest Fwy., Ste. 300
   Address: Houston, TX 77040
   Email: Requestcenter@marker-group.com
2. Purpose of the release of this information

   ☐ At the request of Patient/Patient's personal representative.
   ☒ Other: Civil Litigation

3. I understand that my PPR may include information related to treatment of mental health condition, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases. I understand that the information, if any, pertaining to any of the conditions described above may be released.

   ☒ I authorize the release of this information.
   ☐ I do not authorize the release of this information.

4. I understand that I may cancel this authorization at any time by writing to CVS Pharmacy Privacy Office, One CVS Drive Woonsocket, RI 02895, or fax to 401-765-9304, except to the extent that CVS Pharmacy has taken action in reliance on this authorization.

5. I understand that signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment from the CVS Pharmacy, any payment for treatment or enrollment or eligibility for benefits. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.

6. I understand that if the person or entity that receives my PPR is not required to comply with the applicable privacy regulations, the information described above may be redisclosed by the recipient and no longer be protected by those regulations.

7. I understand that I have the right to receive a copy of this Authorization.

8. This authorization will expire 6 months from the date I sign it as shown below on this authorization unless I enter a different expiration date here End of litigation.

_____ _____
Signature of Patient or Personal Representative * Date

*If signed by someone other than the patient, please explain your authority to act on behalf of the patient: _____

Walgreens

#3596202

The Pharmacy America Trusts®

Walgreens Custodian of Records Department, 1901 East Voorhees Street PO Box 4039, MS #735, Danville, Illinois 61834 Phone: 217.554.8949

Patient Name: _____ Phone: ( ) _____

Known a/k/a's: _____ Birth: _____

Address: _____

Past Address(es): _____

Person/organization authorized to receive information from Walgreens:

Company: THE MARKER GROUP

Address: 13105 NORTHWEST FREEWAY, SUITE 300 HOUSTON, TX, 77040-

Describe the information that you are asking us to release: Prescription History.

List Specific Date Range (if Applicable) _____

List the specific purpose for requesting this information: At the patient's request.

Expiration Date: (1) One year from date of signature unless otherwise specified.

Information regarding this Authorization: Expiration: End of litigation

- You have the right to revoke this Authorization, in writing to Walgreens Privacy Office, 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.
- Our pharmacy records do not reflect the identity or existence of specific conditions, illnesses, injuries, or accidents. You acknowledge that we cannot redact on these bases and hereby consent that the released PHI may contain HIV, AIDS, STD, Communicable disease, mental health, genetic, or alcohol/substance abuse treatment information.

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

Signature: Date

Signature of Patient or Authorized Representative (State relationship)

Attach documentation of authority to sign on behalf of patient for health care.

Authorization to Release Private Health Information

Walmart
Save money. Live better.
702 SW 8th Street
Bentonville, AR 72716-0215
Phone 479.273.4505
Fax 479.204.9655
rxlegal@walmartlegal.com

Legal
HIPAA Team

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Requestor and Purpose **(If to be released to patient check here ☐ and continue with Section 3)**

Individual or Entity: The Marker Group, Inc.		Person Receiving Information:	
Address: 13105 Northwest Fwy., Ste. 300			
City: Houston	State: TX	Zip: 77040	Phone:

Purpose of Release: ☐ Patient Request ☒ Legal/Attorney Letter ☐ Insurance ☐ Housing

Section 3: Information to be Released (Check All That Apply)

I authorize Walmart to release of the following health information:
☐ Medical Expenses Summary (List of all prescriptions with expense information)
☒ Designated Record Set (Entire medical record maintained by the pharmacy)
☐ Specific Prescription(s): _____
☐ One Line Summary (total number of prescriptions and out-of-pocket expenses)

For the following dates of service:
☒ All dates of service ☐ From _____ to _____

From the following facilities:
☒ All locations where I have had prescriptions filled
☐ Only the following location(s) (include city and state): _____

Section 4: Expiration Date or Event

This authorization will remain in effect
☐ Until the following date: _____
☒ Until the following event occurs: End of litigation
☐ Until one year from the date of my signature below.

Section 5: Understandings

(a) I understand that signing this authorization is voluntary. Receipt of pharmacy services will not be conditioned upon my authorization of this disclosure. (45 C.F.R. 164.508(c)(2)(ii))

(b) I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by federal or state privacy laws. (45 C.F.R. 164.508(c)(2)(iii))

(c) I have the right to revoke this authorization in writing at any time by notifying the Walmart Legal Department. The revocation will not apply to the extent that (i) Walmart has already released health information based on this authorization or (ii) this authorization was obtained as a condition to the patient obtaining insurance or for an insurer to contest a claim. (45 C.F.R. 164.508(c)(2)(i))

(d) I understand that by signing below I authorize the release of records that may include: HIV/AIDS related information and or records; Mental Health Information and or records; Drug/Alcohol Diagnosis and Treatment Information; Pregnancy and Family Planning Information; Sexually Transmitted Disease Information.

Section 6: Signature and Date

_____ _____
Signature of Patient or Personal Representative Date

If you have signed this as a legally authorized representative of the patient, please print your name and relationship to the patient below. If your relationship is anything other than parent of a minor, please include documentation of your authority to sign for the patient's records.

_____ _____
Name of Personal Representative (please print) **Relationship to Patient (parent, guardian, etc.)**

EXPRESS SCRIPTS®

Authorization to Use and Disclose Health Information

PLEASE PRINT CLEARLY

Patient's Name: _____ ID Number_____

Address: _____ SSN: _____
Street

_____ Date of Birth: _____/_____/_____
City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) _____

[ ] Check here if Plan Sponsor is Department of Defense

I authorize Express Scripts, Inc. or one of its subsidiaries or affiliates to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
[X] PBM Prescription Claims Information
[X] Only Mail Order Pharmacy Records are requested

2. The health information identified above may be used or disclosed for the following purpose(s):

Civil Litigation

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

Name: The Marker Group, Inc.

Address: 13105 Northwest Fwy., Ste. 300
Houston, TX 77040

E-mail Address Requestcenter@marker-group.com

4. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

7. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed by Express Scripts, Inc. once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

   Express Scripts, Inc.
   Claims Dept – Records/B402-01
   8931 Springdale Avenue
   St. Louis, MO 63134
   FAX: 866-254-2313

8. I understand that I have a right to request and receive a copy of Express Scripts' Notice of Privacy Practices at www.express-scripts.com.

9. A photocopy of this authorization is as valid as the original.

10. I understand that this authorization will expire ten (10) years from the date signed below.

SIGNATURE

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

If signed by patient's personal representative, please complete the following and attach supporting documentation:

Relationship to patient: _____

Authority to act for the patient:_____

Prescription Claims Information is readily available for the previous ten years. Patients wanting prescription claim information sent to the address on file should call the number on the back of the prescription identification card

Members wanting PBM Prescription Claim Information sent to the address on file free of charge should call the number on the back of the prescription identification card. The Express Scripts website also provides all members the ability to access and print PBM Prescription Claim Information for free for the last 24 months of service by logging into www.express-scripts.com.

Please return the completed form to the address below. For those requests for PBM Prescription Claims Information not submitted by a member's legal personal representative, please also submit a check or money order for the non-refundable fee of $90.00.

Express Scripts, Inc.
Claims Dept – Records/B402-01
8931 Springdale Avenue
St. Louis MO 63134
Fax 866-254-2313

Email: Prescriptionhistoryrequests@express-scripts.com

Please allow 6-8 weeks for the request to be processed. For questions or concerns, please call toll-free 800-332-5455, ext 326584.

MEMBER AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*** Required Field**

Member Information (identifying the individual whose information is to be released)

** Member Name:* _____

** Member ID / SSN:* _____

Member Address: _____

Member Phone No.: _____

** Date of Birth:* _____
(Month, Day, Year)

Group No.: _____

I authorize the use or disclosure of the above-named member's personal and health information by Humana as described below: *Check Box

☒ Any and all Claims Records in your possession,
  ☒ Check this box to include mental health, HIV records, and/or substance abuse records)

☐ Claims records for the time period_____to_____.

☐ Claims records relating to_____for the time period_____to_____.
(Insert specific injury or condition.)

☐ Claims submitted by_____for the timeperiod_____to_____.
(Insert provider's name.)

☒ Prescription drug claims **(include dates)**:_____.

☐ Other **(Be specific; include dates.)**: _____
_____.

* This information may be disclosed to, and used by, the following individual(s) or organization(s):

Name: The Marker Group, Inc.

Address: 13105 Northwest Fwy., Ste. 300, Houston, TX 77040
PH: 713-934-2724 Fax: 713-924-2723 Email: requestcenter@marker-group.com

* This protected health information is being used or disclosed for the following purpose(s): _____
Civil Litigation
_____.

* I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to; *HUMANA - 1100 Employers Blvd Green Bay, WI 54344*
and/or _____

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that Humana may not condition eligibility or enrollment, and payment on whether I sign this authorization

I understand that information used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under state or federal law. I also have the right to refuse to sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I release Humana from any liability associated with releasing this information to the persons and/or Organizations named above.

If this authorization is signed by a legal representative, please provide representative documentation as required by state law (i.e., Power of Attorney, Health Care Surrogate, Living Will, or Guardianship papers).

Unless otherwise specified, this authorization will expire 90 days after the date (as shown at the end of this document) of my signature._____.

* _____
Name of Member or Personal Representative

_____
If Personal Representative,
Relationship to Member

* _____
Signature or Member or Personal Representative

* _____
Date of Signature

_____
Signature of Witness

_____
Date

I have received a copy of this form. _____
(signor's initials)

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Cigna, its agents or subsidiaries to disclose the Protected Health Information (PHI) indicated below to the persons or entities specified on this form.

Please print your responses on this form. All sections must be completed for this authorization to be valid.

VERIFICATION – (Please print)

Identification of customer:

(The following information is needed for verification. Please complete all applicable items.)

Name of customer whose information will be disclosed: _____ Date of birth: _____

Phone number where we can reach you if we need to contact you to process your request (required): _____

Customer address: _____

_____

Medicare ID #: _____ Customer ID card # (if applicable): _____

Description of Information to be Released _____

Please indicate what information you wish to release by checking one or more of the boxes below.

RECORDS TO BE DISCLOSED (check all that apply):

Information requested from records maintained by Cigna.

☐ All records ☐ Claims ☐ Eligibility/benefits ☐ Billing records ☐ Medical

Other information (please describe): _____

_____

Customer must initial in the space provided if any of the boxes below are checked.

_____ ☐ Drug/alcohol diagnosis, treatment and referral

_____ ☐ HIV/AIDS information

_____ ☐ Mental health diagnosis, treatment and referral

_____ ☐ Genetic testing information

Dates of service (if applicable): _____ to _____

☐ Check if this authorization is for notes from private therapy sessions **(if this box is checked, a separate authorization form must be used for any other type of protected health information)**.

Please complete the other side.

Arizona residents – The information authorized for release may include records concerning communicable or venereal diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Arizona Revised Statutes 36-664 if this type of information is to be released.

Oklahoma residents – The information authorized for release may include records concerning a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Section 1-502.2 of the Oklahoma Statutes if this type of information is to be released.

Entity or person authorized to receive information:

Name: _____ Company (if applicable): _____

Phone number: 713-934-2734

Address of individual or company authorized to receive the information: _____

_____

PURPOSE OF RELEASE

☐ Medical care ☐ Insurance ☐ At the request of the patient

Other (please explain): _____

_____

EXPIRATION OF AUTHORIZATION

This authorization expires: _____ (date or event)

If no expiration date or event is noted, this authorization will expire one year from the date signed.

PLEASE NOTE

- You may refuse to sign this authorization and it is strictly voluntary.
- Information disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy regulations.
- If the information on this form is not complete, Cigna will return the form to you, and this request will not be considered until Cigna receives complete information.
- If your customer ID or date of birth changes, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to Cigna, at the address below. You can obtain a Change/Revoke form by calling Cigna at the number on your Cigna ID card.
- The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether you sign this authorization. However, if the information is needed to determine the payment of a claim, refusal to sign this form may result in nonpayment of the claim.

Please complete the other side.

SIGNATURE

I have read and understand the above information. Date: _____

Signature of customer, parent/guardian, other person legally authorized to act on behalf of the customer:

_____

Relationship, if signed by other than customer: _____

Note that, if not already provided, we will require verification of the authority of another person to act on behalf of the customer before this request will be considered complete.

If customer is unable to give consent because of age, complete the following:

Customer is a minor, _____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

We recommend that you keep a copy of your completed form for your records. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with your original health records.

COMPLETED FORM MAILING ADDRESSES

Please send your completed form to your plan's corresponding address below:

Cigna Medicare Advantage Plan

Cigna Privacy Office
PO Box 188014
Chattanooga, TN 37422

Cigna Medicare Prescription Drug Plan

Cigna
PO Box 269005
Weston, FL 33326-9927

Please maintain a copy of this form for your records.

EXHIBIT D

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the 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. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

The Marker Group, Inc.

***ADDRESS OF PERSON OR ORGANIZATION:**

13105 Northwest Fwy., Ste. 300

Houston, TX 77040

***I want this information released because:** Civil Litigation

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☒ My benefit or payment amounts from date _____ to date present
5. ☒ My Medicare entitlement from date _____ to date present
6. ☒ Medical records from my claims folder(s) from date _____ to date present

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Consultative exams, award/denial notices, benefit applications, appeals, questionnaires,

   doctor reports and determinations

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Form **4506**

(November 2020)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

The Marker Group, Inc., 13105 Northwest Fwy., Ste. 300, Houston, TX 77040
PH: 713-934-2724; FAX: 713-934-2723; Email: requestcenter@marker-group.com

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ 43.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____ _____
Print/Type name **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

▶ _____
Print/Type name

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

**ALL SECTIONS REQUIRED

Medicare Authorization Form

Section A: Beneficiary Information		
Name (As it appears on Medicare card):		
Date of Birth:	Medicare ID Number:	
Address:		
City:	State:	ZIP Code:

Section B: Record Time Frame Definition

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** item: ☒ Release **all** records OR ☐ Timeframe of claim records from start date _____ to end date: _____

NY RESIDENTS MUST ALSO SELECT: ☐ Release **all** records OR ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Identify a future date or event when the authorization will expire (one time disclosure if no date or event provided).

☐ Specified Date _____ OR ☒ Event _____End of litigation_____

Section C: Release Information To

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

1. Organization/Individual Name and Contact:	The Marker Group, Inc.
Organization/Individual Mailing Address:	13105 Northwest Fwy., Ste. 300 Houston, TX 77040 Email: requestcenter@marker-group.com
2. Organization/Individual Name and Contact:	
Organization/Individual Mailing Address:	

Section D: Purpose for Request

This section helps Medicare understand the reason or intent for use for this record request.

☐ At the request of the individual	☒ Litigation

Section E: Authorization Agreement

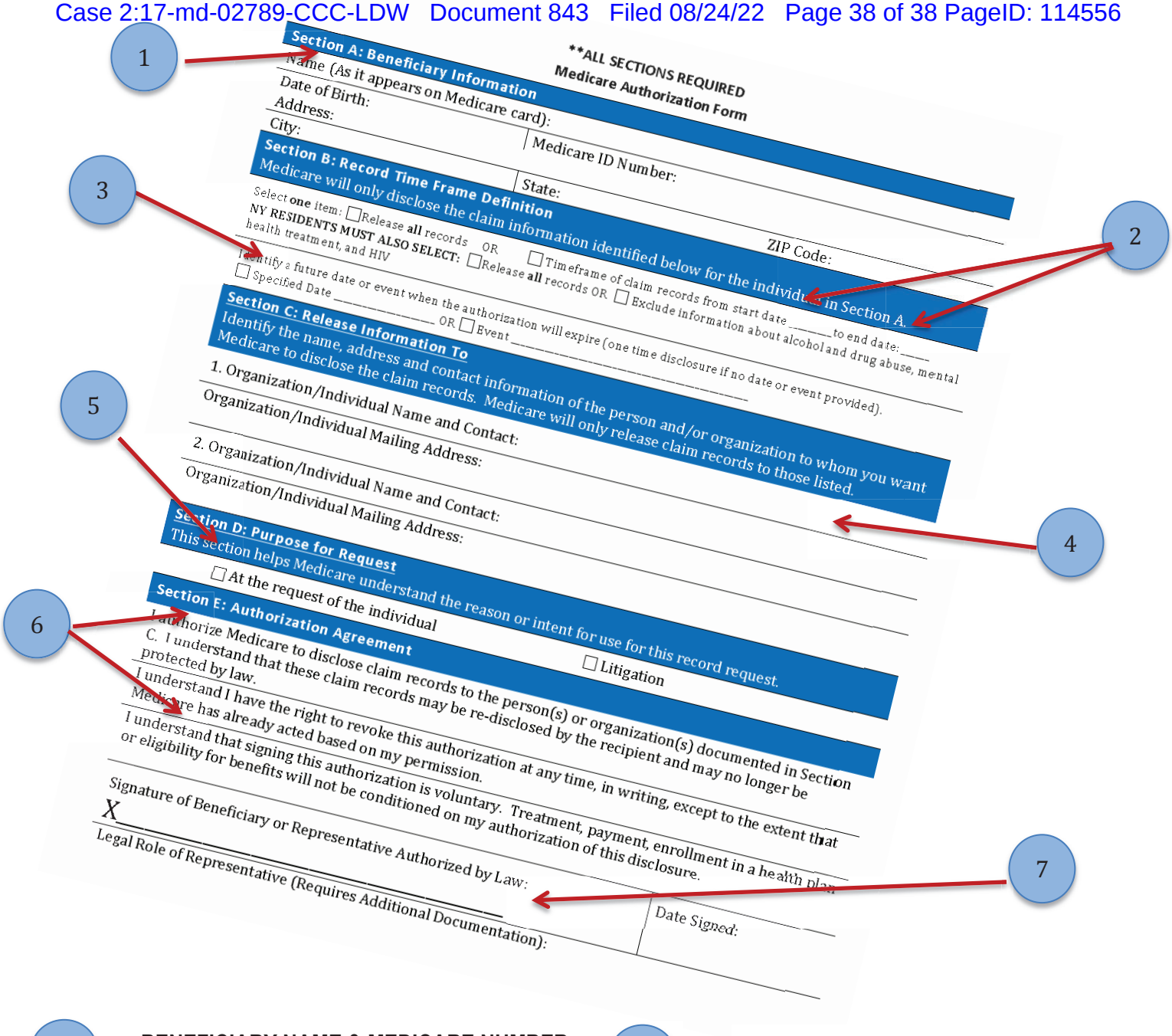
I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law: X_____	Date Signed:

Legal Role of Representative (Requires Additional Documentation):



1 **BENEFICIARY NAME & MEDICARE NUMBER**
As it appears on the Medicare Card

2 **RECORD TIMEFRAME**
Select date range if not selecting "ALL RECORDS"

NY Residents-additional required selection

3 **SELECT EXPIRATION DATE**
If specific date or event required

4 **SPECIFY ORGANIZATION TO RELEASE TO**
Must include contact first and last name and address

5 **SELECT REASON FOR REQUEST**
This includes litigation and "by request of the individual"

6 **REQUIRED AUTHORIZATION CLAUSES**
HIPPA clauses required to release information

7 **BENEFICIARY SIGNATURE**
Signed and dated by beneficiary or authorized representative (If not signed by beneficiary; note that POA or Letters Testamentary are required)