IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

	:	**MDL DOCKET NO. 4:03-CV-1507-WRW**
IN RE:	:	
PREMPRO PRODUCTS LIABILITY	:	
LITIGATION	:	**ALL CASES**

ORDER Re: FACT SHEETS

Over the years, repeatedly questions have been raised as to who should be served with completed Fact Sheets and how. After a review of the record, I am not sure this procedure was ever explicitly set out (at least, not in one concise Order), so I will do so now.

Fact Sheets must be served as set out below:

1. Each plaintiff must complete and serve each defendant with her completed Fact Sheet within 90 days after her Conditional Transfer Order becomes final. However, if the parties wish to stipulate among themselves to a different start date, they may.[1]

2. Fact Sheets are not to be filed with the Court.

3. Each plaintiff must serve hard copies of completed Fact Sheets on defendants' lead and liaison counsel.[2] Their addresses are:

Lead Counsel:
Mr. Lane Heard
Williams & Connolly LLP
725 Twelfth Street, N.W.
Washington, DC 20005

Liaison Counsel:
Ms. Lyn Pruitt
Mitchell, Williams, Selig, Gates & Woodyard, PLLC
425 West Capitol Ave, Suite 1800
Little Rock, AR 72201

[1]See Doc. No. 1093.

[2]See Doc. No. 377.

4. In addition to serving hard copies, each plaintiff must electronically serve her Fact Sheet to all concerned defendants.[3] For electronic service on manufacturer defendants, plaintiffs may email the electronic copies to hrtfactsheets@wc.com -- Wyeth has agreed distribute the electronic copies to other manufacturer defendants. Plaintiffs will remain responsible for serving electronic copies on all non-manufacturer defendants.

5. For convenience, a copy of the Fact Sheet is attached to this Order.

IT IS SO ORDERED this 13th day of January, 2009.

/s/ Wm. R. Wilson, Jr.
UNITED STATES DISTRICT COURT

[3]See *Id.*

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

In re:	:	**MDL Docket No. 4:03CV1507 WRW**
PREMPRO PRODUCTS LIABILITY LITIGATION	:	**ALL CASES**

PLAINTIFF'S FACT SHEET

PLAINTIFF'S NAME: _____

This Fact Sheet and the attached List of Medical Providers and Other Sources of Information must be completed by each plaintiff in the ML Prempro Products Liability Litigation who used Hormone Therapy (HT) medications or who is the representative of a person or the estate of a deceased person who used HT. For each question, where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete.

Information provided by plaintiff within the fact sheet will only be used for purposes related to this litigation and such information will not be disclosed outside this litigation without plaintiff's written consent. Plaintiffs' Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery.

Please note: HT = "hormone therapy drugs"

I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption: _____

2. MDL Cause Number :_____

3. Please provide plaintiff's name and address:

_____
Name

_____
Street Address

_____
City, State, and Zip Code

4. Please state name, address, telephone number, fax number and e-mail address of principal attorney representing you.

Attorney Name:
Firm:

Telephone Number:
FAX Number:

E-Mail Address:

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

Your name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

In what capacity are you representing the individual? _____

If you were appointed by a court, state the:

_____
State, Court Term and Number Date of Appointment

Your relationship to deceased or represented person: _____

State the date of death of the decedent._____

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used HT medications. Those questions using the term "You" refer to the person who used the HT medications. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

C. Claim Information

1. Do you claim that you have suffered a bodily injury as a result of the use of HT medications? Yes _____ No _____

If the answer to the foregoing question is yes, state the nature of the bodily injury or injuries which you claim.

_____

_____

2. If you do not claim you have suffered a bodily injury as a result of the use of HT medications, state how you have been injured.

_____

3. Identify by name, specialty, address and phone number any doctor(s) who told you that you are injured.

Name: _____ Specialty: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

D. **Hormone Therapy used** - Identify by complete brand name and/or trade name the HT medications you claim caused your injuries, including the specific type of the medication or product, a description of what the medication looked like, the NDC codes for the medication, and the dates of your use. Answers may be provided by attaching pharmacy records and/or providing NDC codes of any HT medication(s) ingested.

_____

E. **Prescribing Physicians** - Identify by name, specialty, and address the doctor(s) who prescribed these HT medications for you and, for each doctor, provide the dates during which he or she prescribed the HT medication.

1. Name: _____ Specialty: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Dates: _____ Hospital: _____

2. Name: _____ Specialty: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Dates: _____ Hospital: _____

3. Name: _____ Specialty: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Dates: _____ Hospital: _____

F. **Samples** - Did you ever receive sample HT products from any of your healthcare providers? Yes _____ No _____

If yes, please state:

1. From what doctor?_____
2. When?_____
3. Identify the specific products included in the samples._____

_____

II. PERSONAL INFORMATION

A. _____

Last Name First Name Middle Initial

B. Maiden or other names used or by which you have been known, and the dates during which you were known by such names:

_____

C. Current or last employer:

_____

Name

_____

Street Address, City, State and Zip Code

_____

Dates of Employment

_____

Occupation

D. Social Security Number: _____

E. Do you have a driver's license? Yes _____ No _____

Have you ever had your driving privileges suspended or limited based on your health or physical condition? Yes _____ No _____

If so, when and for what reason(s)? _____

_____

F. Date and Place of Birth: _____

G. Sex: Male _____ Female _____

H. Because many diseases and conditions related to this litigation may be more or less prevalent in certain racial and ethnic groups, please identify your racial and ethnic background:

Racial and Ethnic Background: _____

I. Have you ever served in any branch of the military? Yes _____ No _____

1. Branch and dates of service:

_____

2. Were you discharged for any reason relating to your health or physical condition: Yes _____ No _____

If yes, state what that condition was.

_____

Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes _____ No _____

J. Have you ever filed a worker's compensation claim? Yes _____ No _____

If yes, please state:

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Claim/docket number, if applicable: _____

4. Nature of claimed injury: _____

5. Period of disability: _____

[Attach additional sheets as necessary to describe more than one claim.]

K. Have you ever made a social security disability claim? Yes _____ No _____

If yes, please state:

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Nature of disability: _____

4. Period of disability: _____

[Attach additional sheets as necessary to describe more than one clam.]

L. Have you ever made any other form of disability claim? Yes _____ No _____

If yes, please state:

Year claim was filed: _____

Where claim was filed: _____

Name of insurer/employer or other party to whom claim was made: _____

_____

Nature of disability: _____

Period of disability: _____

M. Have you ever been denied life insurance for reasons relating to your health?

Yes _____ No _____

If yes, please state when, the name of the company and the company's stated reason for denial.

_____

N. Within the last ten (10) years, have you filed a lawsuit or made a claim, other than in the present suit, seeking damages for personal injury or medical malpractice? Yes _____ No _____

If yes, state the state and county in which claim was filed, the caption, case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action or suit.

_____

_____

Have you *ever* filed a lawsuit or made a claim, other than in the present suit, seeking damages for the injuries you claim in this case? Yes _____ No _____

If yes, state the state and county in which claim was filed, the caption, case name and/or names of adverse parties, the injuries claimed, and the civil action or docket number assigned to each such claim, action or suit.

_____

O. Have you been convicted of, or pled guilty to, a felony within the last 10 years? Yes _____ No _____

If so, describe the crime or offense, the state and county in which convicted, and the outcome of the charge.

_____

_____

P. Identify each address at which you have resided during the last ten (10) years, including time periods of residence.

_____

_____

_____

Q. Have you had access to a computer at any time over the past five (5) years? Yes _____ No _____

If "yes," then answer the following:

1. Did you ever visit any website containing information regarding hormone therapy or the treatment of menopausal systems? Yes _____ No _____

2. Did you ever visit any chat rooms? Yes _____ No _____

3. Did you ever communicate via email or chat room regarding hormone therapy or the treatment of menopausal systems?
Yes _____ No _____

III. EMPLOYMENT HISTORY

Identify each employer since 1990, dates of each such employment and positions held. If you are making a claim for lost wages in this case, also list, for each position, your salary and/or other compensation received:

_____

_____

_____

Have you ever been out of work for more than thirty (30) days for reasons related to your health, including pregnancy? Yes _____ No _____

If yes, please state the dates, employer and health condition:

_____

_____

IV. EDUCATIONAL HISTORY

Identify each high school, vocational school, college, university or other post-secondary educational institution you have attended, the dates of attendance, and diplomas or degrees awarded:

_____

_____

V. FAMILY INFORMATION

a. Have you ever been married? Yes _____ No _____

b. If you have been married, for each spouse, state:

i. Spouse's name: _____

ii. Dates of marriage: _____

iii. Spouse's date of birth: _____

iv. Spouse's occupation: _____

v. Spouse's address: _____

c. Has your spouse filed a loss of consortium or other claim? Yes _____ No _____

d. Please provide the following information for your parents, grandparents, siblings and children:

Name	Relationship	Date of Birth

Va. PREGNANCY HISTORY

1. During pregnancy, did you experience any miscarriages? Yes _____ No ____

If yes, please list the approximate date of the miscarriage, state how many weeks you had been pregnant when the miscarriage occurred and the cause of any such miscarriage.

_____

_____

_____

2. During pregnancy, did you experience any of the following:

Toxemia: Yes _____ No _____

High blood pressure: Yes _____ No _____

Gestational diabetes: Yes _____ No _____

Large babies (over 9 pounds): Yes _____ No _____

Pre-eclampsia: Yes _____ No _____

Premature labor(s): Yes _____ No _____

Premature birth(s): Yes _____ No _____

Small babies (6 lbs. or less): Yes _____ No _____

For each "yes" you have checked above, provide the dates and (if appropriate) treatment:

_____

_____

3. Were you placed on bed rest during any pregnancy? Yes _____ No _____

If yes, describe length of bed rest and reasons for it:

_____

_____

4. Did you take any hormones or medications during pregnancy? Yes _____ No _____

If yes, list medications, prescribing doctor, and reasons for taking:

_____

_____

5. How much weight did you gain during each pregnancy:

_____

6. Did you breastfeed your children? Yes _____ No _____

If so, for how long did you breastfeed each child?

_____

7. Were you ever treated for infertility? Yes _____ No _____

If yes, identify the dates of treatment, the medical provider(s) who treated you, and the treatment(s) undertaken, including any medications you took.

_____

8. Is your blood type RH negative? Yes _____ No _____

For each of your pregnancies, list the gynecologist, obstetrician, or other medical care provider who treated you and, for each time you gave birth, the hospital at which you delivered:

1. Name: _____ Specialty: _____

   Street address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

   Dates: _____ Hospital: _____

2. Name: _____ Specialty: _____

   Street address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

   Dates: _____ Hospital: _____

3. Name: _____ Specialty: _____

   Street address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

   Dates: _____ Hospital: _____

VI. LIST OF HEALTHCARE PROVIDERS

A. List the name and address of your current primary care physician(s) or provider:

   Name: _____ Approximate dates: _____

   Last known address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

B. **Primary care physicians -** To the best of your ability, identify each of the primary care physicians or providers who have treated you since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier.

1. Name: _____ Approximate dates: _____

Last known address: _____

City: _____ State: _____ Zip: _____ Phone: _____

2. Name: _____ Approximate dates: _____

Last known address: _____

City: _____ State: _____ Zip: _____ Phone: _____

3. Name: _____ Approximate dates: _____

Last known address: _____

City: _____ State: _____ Zip: _____ Phone: _____

C. **Ob/ Gyn** – Identify each obstetrician or gynecologist who has seen or treated you since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier, other than those you already listed earlier in response to questions about your pregnancies.:

1. Name: _____ Specialty: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

2. Name: _____ Specialty: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

3. Name: _____ Specialty: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

D. **In-patient treatment –** Identify each hospital where you have received inpatient treatment since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier.

1. Name: _____ Reason for treatment: _____

   Street address: _____

   City: _____ State: _____ Zip: _____

2. Name: _____ Reason for treatment: _____

   Street address: _____

   City: _____ State: _____ Zip: _____

3. Name: _____ Reason for treatment: _____

   Street address: _____

   City: _____ State: _____ Zip: _____

E. **Out-patient treatment** – Identify each hospital or healthcare facility or provider where you have received out-patient treatment (including emergency room treatment and outpatient surgery) or tests since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier:

1. Name: _____

   Treatment or tests received: _____

   Street address: _____

   City: _____ State: _____ Zip: _____

2. Name: _____

   Treatment or tests received: _____

   Street address: _____

   City: _____ State: _____ Zip: _____

3. Name: _____

Treatment or tests received: _____

Street address: _____

City: _____ State: _____ Zip: _____

4. Name: _____

Treatment or tests received: _____

Street address: _____

City: _____ State: _____ Zip: _____

5. Name: _____

Treatment or tests received: _____

Street address: _____

City: _____ State: _____ Zip: _____

F. **All doctors** – Identify each *other* physician or healthcare provider from whom you have received treatment, with whom you have consulted regarding your health, or who has examined you since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier:

1. Name: _____

Specialty & reason for consult: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

2. Name: _____

Specialty & reason for consult: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

3. Name: _____

Specialty & reason for consult: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

4. Name: _____

Specialty & reason for consult: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

5. Name: _____

Specialty & reason for consult: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

G. **Pharmacy** – Identify each pharmacy, drugstore and/or other supplier (including mail order) where you have had prescriptions filled or from which you have ever received any prescription medication since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier. Also list all pharmacy, drugstore and/or other supplier (including mail order) where you remember having prescriptions filled for oral contraceptives or from which you ever remember receiving oral contraceptives (birth control pills).

1. Name: _____

Medication and Reason for Prescription: _____

Street address: _____

City: _____ State: _____ Zip: _____

2. Name: _____

Medication and Reason for Prescription: _____

Street address: _____

City: _____ State: _____ Zip: _____

3. Name: _____

Medication and Reason for Prescription: _____

Street address: _____

City: _____ State: _____ Zip: _____

4. Name: _____

Medication and Reason for Prescription: _____

Street address: _____

City: _____ State: _____ Zip: _____

5. Name: _____

Medication and Reason for Prescription: _____

Street address: _____

City: _____ State: _____ Zip: _____

H. **Insurance carrier** - Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last twenty years, with the named insured and named insured's social security number.

Carrier	***Policy Number***	***Named Insured***	***Social Security No.***

VII. CURRENT MEDICAL CONDITION

A. Do you currently suffer from any physical injuries, illnesses or disabilities that you believe were caused by Hormone Therapy? Yes _____ No _____

If yes, identify the injury, illness, or disability, symptoms, date(s) of onset and date(s) of diagnosis:

Injury, illness or disability: _____

_____

_____

Symptoms: _____

Date(s) of onset: _____

Date(s) of diagnoses: _____

Physician Name by whom first diagnosed:_____

Specialty: _____

Address (if not otherwise provided): _____

B. Do you currently suffer from any physical injuries, illnesses or disabilities *other than* those that you believe were caused by HT medications? Yes _____ No _____

If yes, identify the injury, illness, or disability, symptoms, date(s) of onset and date(s) of diagnosis:

Injury, illness or disability: _____

Symptoms: _____

Date(s) of onset: _____

Date(s) of diagnoses: _____

Physician Name by whom first diagnosed:_____

Specialty: _____

Address (if not otherwise provided): _____

VIII. PLAINTIFF'S HEALTH HISTORY

A. **Body measurements**

Current height: _____ Current weight:_____

Weight at time of injury:_____ Weight when first prescribed HT: _____

Lowest weight during adulthood (and date): _____

Highest weight during adulthood (and date): _____

Current waist measurement: _____ Current hip measurement: _____

Has any healthcare provider ever recommended any change in your habits (for example, losing weight, lowering blood pressure, getting exercise, reducing cholesterol)?

Yes _____ No _____

If yes, please list the recommendation, the date(s) made, and the healthcare provider:

_____

_____

B. **Menstrual History:**

Date and age of first menstrual period: _____

Date and age of last menstrual period: _____

Were your menstrual cycles regular? Yes _____ No _____

If yes, average length of cycle: _____ Average length of period: _____

If no, describe your cycles and periods: _____

_____

Did you ever experience menstrual problems (including irregular periods, painful periods, or absence of periods) for which you sought medical treatment or advice? Yes ___ No __

If yes, please give dates and description of problem, the provider consulted, and any treatment:

_____

_____

_____

Have you ever been diagnosed with polycystic ovary syndrome? Yes _____ No _____

If yes, please identify healthcare provider who diagnosed you, dates of diagnosis, and treatment:

_____

_____

Have you ever been diagnosed with endometriosis? Yes _____ No _____

If yes, please identify healthcare provider who diagnosed you, dates of diagnosis, and treatment:

_____

_____

Have you ever been diagnosed with fibroids anywhere in your body? Yes ___ No ____

If yes, please identify healthcare provider who diagnosed you, dates of diagnosis, and treatment:

_____

_____

C. **Menopause History:**

Age at menopause: _____

Pre-menopausal symptoms: _____

_____

Symptoms at menopause experienced before starting hormone therapy:

_____

Symptoms of menopause experienced after ending hormone therapy:

_____

_____

D. **Mammogram History**
(Answer questions in this Section ONLY if you are making a claim for breast cancer):

Did you have any mammograms before you reached menopause? Yes _____ No _____

If yes, list dates, healthcare facility (by name and address) where you received each mammogram, and results of the mammogram:

_____

_____

_____

How frequently have you had a mammogram since menopause?

_____

For each such mammogram, list dates, healthcare facility (by name and address) where you received each mammogram and results of the mammogram:

_____

_____

_____

Has a healthcare provider ever recommended follow-up testing as a result of a mammogram or have you undergone such testing? Yes _____ No _____

If yes, describe the follow-up, including dates, type of follow-up, and location (by name and address) of such follow-up:

_____

_____

Do you do breast self-exams? Yes _____ No _____

For how long have you done these exams and with what frequency?

_____

Have you ever found anything during a self-exam? Yes _____ No _____

If yes, please explain, including relevant dates:

_____

_____

Have you ever been told that you have dense breasts? Yes _____ No _____

If yes, please identify the healthcare practitioner who informed you and the date(s) on which you were given this information:

_____

Have you ever been told you have fibrocystic breasts? Yes _____ No _____

If yes, please identify the healthcare practitioner who informed you and the date(s) on which you were given this information:

_____

E. Medications:

Do you currently take or have you *ever* taken oral contraceptives (i.e. birth control pills) or other hormones (for any reason, such as birth control, irregular period, etc.)

Yes _____ No _____ Don't Know _____

Do you currently take, or have you taken since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier, any of the following:

1. Anticoagulants (such as aspirin, Coumadin, warfarin, fragmin or heparin)

   Yes _____ No _____ Don't Know _____

2. Heart medications:

   Yes _____ No _____ Don't Know ____

3. Blood pressure medication:

   Yes _____ No _____ Don't Know ____

4. Ephedra:

   Yes _____ No _____ Don't Know ____

5. Diet Medications:

   Yes _____ No _____ Don't Know ____

6. Diuretics (fluid retention medications)

   Yes ___ No ___ Don't Know ___

7. Any other prescription medicines regularly taken since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier:

   Yes _____ No _____ Don't Know ____

For each "yes" you have checked above, including oral contraceptives, provide the precise name of the medication/substance, the time period(s) you took it (including the dates first and last taken), and the reasons your physician prescribed it, if known:

Medication	***Date First Taken***	***Date Last Taken***	***Reason for Prescription/Use***

F. Smoking history (check wherever appropriate)

1. Have you ever smoked cigarettes? Yes _____ No _____ (If no, skip to F. 5)

   State amount smoked:____ packs per day for _____ years, during the years _____ to _____.

2. Do you currently smoke cigarettes? Yes _____ No _____

   If yes, state amount smoked: _____ packs per day

   If no, state date on which smoking ceased: _____

3. Were you a cigarette smoker when you began, or during, hormone therapy? Yes ___ No ___

   If yes, state amount smoked during that time: _____ packs per day

4. At the time that you sustained the injuries alleged in this lawsuit, were you a smoker of cigarettes? Yes _____ No _____

   If yes, state amount smoked at that time: _____ packs per day

5. Have you ever smoked cigars or pipe tobacco? Yes _____ No _____ (If no, skip to G)

If yes, State amount smoked:____ cigars/pipes per day for _____ years, during the years _____ to _____.

6. Do you currently smoke cigars or pipe tobacco? Yes ____ No _____

If yes, state amount smoked: _____ cigars/pipes per day

If no, state date on which smoking ceased: _____

7. Were you a pipe or cigar smoker when you began, or during, hormone therapy? Yes ___ No ___

If yes, state amount smoked during that time: _____ cigars/pipes per day

8. At the time that you sustained the injuries alleged in this lawsuit, were you a smoker of cigars or pipe tobacco? Yes _____ No _____

If yes, state amount smoked at that time: _____ cigars/pipes per day

G. Drinking History

Do you currently drink alcohol (beer, wine, whiskey, etc.)? Yes _____ No _____

If yes, check which represents your typical alcohol consumption?

_____ 1 – 2 drinks per day
_____ 1 - 6 drinks per week
_____ 6 – 10 drinks per week
_____ 10 or more drinks per week
_____ Other (explain:_____)

H. Caffeine History

Do you currently drink caffeinated beverages (coffee, tea, sodas, etc.)? Yes _____No _____

If yes, check which represents your current caffeine consumption for each type of caffeine drink:

Beverage: _____ Beverage: _____

_____ 1 – 3 drinks per day
_____ 3 – 5 drinks per day
_____ 6 or more drinks per day

_____ 1 – 3 drinks per day
_____ 3 – 5 drinks per day
_____ 6 or more drinks per day

I. **Prior medical problems**: To the best of your knowledge, have *you* ever experienced or been diagnosed or treated for any of the following?

1.	Cancer	Yes___ No___ Unknown___
2.	Having BRCA1 or BRCA2 Gene or any other factor increasing your risk of breast or ovarian cancer	Yes___ No___ Unknown___
3.	Ectopic pregnancy	Yes___ No___ Unknown___
4.	Abnormal pap smear	Yes___ No___ Unknown___
5.	Abnormal mammogram	Yes___ No___ Unknown___
6.	"Bad" mammogram	Yes___ No___ Unknown___
7.	Obesity	Yes___ No___ Unknown___
8.	Autoimmune disease or condition such as lupus, rheumatoid arthritis, psoriasis, scleroderma or mixed-connective tissue disorder	Yes___ No___ Unknown___
9.	Rheumatological condition	Yes___ No___ Unknown___
10.	Diabetes	Yes___ No___ Unknown___
11.	Glucose Intolerance	Yes___ No___ Unknown___
12.	Vasculitis	Yes___ No___ Unknown___
13.	High triglycerides	Yes___ No___ Unknown___
14.	Arthritis	Yes___ No___ Unknown___
15.	Low HDL Cholesterol	Yes___ No___ Unknown___
16.	High LDL Cholesterol	Yes___ No___ Unknown___
17.	Increased c-reactive protein (CRP) levels	Yes___ No___ Unknown___
18.	Antiphospholipid antibodies	Yes___ No___ Unknown___
19.	Ovarian cysts	Yes___ No___ Unknown___
20.	Radiation treatments	Yes___ No___ Unknown___
21.	Osteoporosis	Yes___ No___ Unknown___
22.	Low bone mineral density	Yes___ No___ Unknown___
23.	Gall bladder disease or problems	Yes___ No___ Unknown___
24.	Thyroid Disease or problems	Yes___ No___ Unknown___

25.	Hypertension or high blood pressure	Yes___	No___	Unknown___
26.	Aneurysm	Yes___	No___	Unknown___
27.	Abnormality of blood vessels or circulatory system	Yes___	No___	Unknown___
28.	Blood clots or thrombosis	Yes___	No___	Unknown___
29.	Blood disorders or dyscrasias (abnormal blood cells)	Yes___	No___	Unknown___
30.	Hypercoagulable conditions (i.e. conditions, whether genetic or acquired, in which your blood clots too much)	Yes___	No___	Unknown___
31.	Any other blood clotting disorder	Yes___	No___	Unknown___
32.	Stroke of any type (e.g., hemorrhagic stroke, ischemic stroke, intracranial hemorrhage, intracerebral hemorrhage, subarachnoid hemorrhage, lacunar stroke)	Yes___	No___	Unknown___
33.	Transient ischemic attach (TIA)	Yes___	No___	Unknown___
34.	Heart disease or condition	Yes___	No___	Unknown___
35.	Cerebrovascular disease or condition	Yes___	No___	Unknown___
36.	Heart valve disease or abnormality	Yes___	No___	Unknown___
37.	Heart attack	Yes___	No___	Unknown___
38.	Mitral valve prolapse	Yes___	No___	Unknown___
39.	Atherosclerosis (clogged arteries or plaque in arteries)	Yes___	No___	Unknown___
40.	High cholesterol	Yes___	No___	Unknown___
41.	Irregular heart beat, atrial fibrillation, arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)	Yes___	No___	Unknown___
42.	Angina (chest pain)	Yes___	No___	Unknown___
43.	Bleeding disorder	Yes___	No___	Unknown___
44.	Phlebitis	Yes___	No___	Unknown___
45.	Deep Vein Thrombosis (DVT)	Yes___	No___	Unknown___

46.	Portal Vein Thrombosis	Yes___ No___ Unknown___
47.	Pulmonary Embolism (PE)	Yes___ No___ Unknown___
48.	Macular degeneration	Yes___ No___ Unknown___
49.	Migraine	Yes___ No___ Unknown___
50.	Peripheral vascular disease	Yes___ No___ Unknown___
51.	Varicose veins	Yes___ No___ Unknown___
52.	Retinal Bleed	Yes___ No___ Unknown___
53.	Kidney disease	Yes___ No___ Unknown___

If you responded yes to any of the above, please identify the condition, the date of onset or occurrence and state the name of the physician or other person who made the diagnosis or informed you of the condition (and, if not provided in the accompanying list, the address of the physician or the other person), and any treatment prescribed or given.

1. Condition: _____

   Onset: _____

   Name and address of diagnosing physician or other person:_____

   _____

   Generic name, brand name, strength and daily dose of any medication prescribed:

   _____

   _____

2. Condition: _____

   Onset: _____

   Name and address of diagnosing physician or other person:_____

   _____

   Generic name, brand name, strength and daily dose of any medication prescribed:

   _____

   _____

3. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:_____

_____

Generic name, brand name, strength and daily dose of any medication prescribed:

_____

_____

J. Family Medical History - Please indicate whether, to the best of your knowledge, your *parents, siblings, children* or *grandparents* have experienced, been diagnosed with or treated for any of the following conditions.

If you are making a claim for any kind of *cancer*, you should put a check mark in each of the conditions under category "A" to indicate whether any of your parents, siblings, children or grandparents have experienced, been diagnosed with, or treated for any of the conditions.

If you are making a claim for any *cardiovascular condition*, such as stroke(embolism, thrombosis), blood clots, or heart attack, you should put a check mark in each of the conditions under category "B" to indicate whether any of your parents, siblings, children or grandparents have experienced, been diagnosed with, or treated for any of the conditions.

Category A (Claim for Cancer)

1.	Cancer	Yes___ No___ Unknown___
2.	Having BRCA1 or BRCA2 Gene or any other factor increasing your risk of breast or ovarian cancer	Yes___ No___ Unknown___
3.	Ectopic pregnancy	Yes___ No___ Unknown___
4.	Abnormal pap smear	Yes___ No___ Unknown___
5.	Abnormal mammogram	Yes___ No___ Unknown___
6.	"Bad" mammogram	Yes___ No___ Unknown___
7.	Obesity	Yes___ No___ Unknown___
8.	Autoimmune disease or condition such as lupus, rheumatoid arthritis, psoriasis, scleroderma or mixed-connective tissue disorder	Yes___ No___ Unknown___

9.	Rheumatological condition	Yes___	No___	Unknown___
10.	Diabetes	Yes___	No___	Unknown___
11.	Glucose Intolerance	Yes___	No___	Unknown___
12.	Vasculitis	Yes___	No___	Unknown___
13.	High triglycerides	Yes___	No___	Unknown___
14.	Arthritis	Yes___	No___	Unknown___
15.	Low HDL Cholesterol	Yes___	No___	Unknown___
16.	High LDL Cholesterol	Yes___	No___	Unknown___
17.	Increased c-reactive protein (CRP) levels	Yes___	No___	Unknown___
18.	Antiphospholipid antibodies	Yes___	No___	Unknown___
19.	Ovarian cysts	Yes___	No___	Unknown___
20.	Radiation treatments	Yes___	No___	Unknown___
21.	Osteoporosis	Yes___	No___	Unknown___
22.	Low bone mineral density	Yes___	No___	Unknown___
23.	Gall bladder disease or problems	Yes___	No___	Unknown___
24.	Thyroid Disease or problems	Yes___	No___	Unknown___

Category B (Claim for Cardiovascular Injury)

1.	Hypertension or high blood pressure	Yes___	No___	Unknown___
2.	Aneurysm	Yes___	No___	Unknown___
3.	Abnormality of blood vessels or circulatory system	Yes___	No___	Unknown___
4.	Blood clots or thrombosis	Yes___	No___	Unknown___
5.	Blood disorders or dyscrasias (abnormal blood cells)	Yes___	No___	Unknown___
6.	Hypercoagulable conditions (i.e. conditions, whether genetic or acquired, in which your blood clots too much)	Yes___	No___	Unknown___
7.	Any other blood clotting disorder	Yes___	No___	Unknown___

8.	Stroke of any type (e.g., hemorrhagic stroke, ischemic stroke, intracranial hemorrhage, intracerebral hemorrhage, subarachnoid hemorrhage, lacunar stroke)	Yes___ No___ Unknown___
9.	Transient ischemic attach (TIA)	Yes___ No___ Unknown___
10.	Heart disease or condition	Yes___ No___ Unknown___
11.	Cerebrovascular disease or condition	Yes___ No___ Unknown___
12.	Heart valve disease or abnormality	Yes___ No___ Unknown___
13.	Heart attack	Yes___ No___ Unknown___
14.	Mitral valve prolapse	Yes___ No___ Unknown___
15.	Atherosclerosis (clogged arteries or plaque in arteries)	Yes___ No___ Unknown___
16.	High cholesterol	Yes___ No___ Unknown___
17.	Irregular heart beat, atrial fibrillation, arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)	Yes___ No___ Unknown___
18.	Angina (chest pain)	Yes___ No___ Unknown___
19.	Bleeding disorder	Yes___ No___ Unknown___
20.	Phlebitis	Yes___ No___ Unknown___
21.	Deep Vein Thrombosis (DVT)	Yes___ No___ Unknown___
22.	Portal Vein Thrombosis	Yes___ No___ Unknown___
23.	Pulmonary Embolism (PE)	Yes___ No___ Unknown___
24.	Migraine	Yes___ No___ Unknown___
25.	Peripheral vascular disease	Yes___ No___ Unknown___
26.	Varicose veins	Yes___ No___ Unknown___
27.	Retinal Bleed	Yes___ No___ Unknown___
28.	Kidney disease	Yes___ No___ Unknown___
29.	Obesity	Yes___ No___ Unknown___

30.	Autoimmune disease or condition such as lupus, rheumatoid arthritis, psoriasis, scleroderma or mixed-connective tissue disorder	Yes___ No___ Unknown___
31.	Rheumatological condition	Yes___ No___ Unknown___
32.	Diabetes	Yes___ No___ Unknown___
33.	Glucose Intolerance	Yes___ No___ Unknown___
34.	Vasculitis	Yes___ No___ Unknown___
35.	High triglycerides	Yes___ No___ Unknown___
36.	Arthritis	Yes___ No___ Unknown___
37.	Low HDL Cholesterol	Yes___ No___ Unknown___
38.	High LDL Cholesterol	Yes___ No___ Unknown___
39.	Increased c-reactive protein (CRP) levels	Yes___ No___ Unknown___
40.	Antiphospholipid antibodies	Yes___ No___ Unknown___
41.	Radiation treatments	Yes___ No___ Unknown___
42.	Osteoporosis	Yes___ No___ Unknown___
43.	Low bone mineral density	Yes___ No___ Unknown___
44.	Gall bladder disease or problems	Yes___ No___ Unknown___
45.	Thyroid Disease or problems	Yes___ No___ Unknown___

If you answered yes to any of the preceding, please identify the person(s) who experienced, was diagnosed with or was treated for that condition.

1. Person: _____ Relationship: _____

   Condition: _____ Date of Onset: _____

   Generic name, brand name, strength and daily dose of any medication prescribed:

   _____

   Name and address of diagnosing physician or other person:_____

   _____

Did this person die from the condition or from complications related to the condition?
Yes _____ No _____

If so, date of death: _____

2. Person: _____ Relationship: _____

Condition: _____ Date of Onset: _____

Generic name, brand name, strength and daily dose of any medication prescribed:

_____

Name and address of diagnosing physician or other person:_____

_____

Did this person die from the condition or from complications related to the condition?
Yes _____ No _____

If so, date of death: _____

K. Emotional claims - Do you claim psychological, psychiatric (including depression), cognitive, or emotional injury as a consequence of using any hormone therapy medications or as a consequence of the physical injuries you claim were caused by hormone therapy? Yes _____ No _____

If yes, identify the following with respect to any psychological, psychiatric (including depression) or emotional problem which you claim was caused by the use of the HT medications at issue.

Name and address of each person who treated you:_____

Street Address (if not otherwise provided): _____

Condition(s) for which treated: _____

When treated: _____

Please state whether you have experienced or been treated for any psychological, psychiatric (including depression), cognitive, or emotional problem ***PRIOR*** to the use of the HT medications at issue. Yes _____ No _____

If yes, please state:

Name and address of each person who treated you:_____

Street Address (if not otherwise provided): _____

Condition(s) for which treated: _____

When treated: _____

L. **Medical Treatments** - Please indicate whether you have received any of the following treatments:

1. Heart, lung or other chest surgery: Yes _____ No _____

   For what condition? _____

   When? _____

   Treating physician: _____

2. Treatment for heart attack or angina: Yes _____ No _____

   For what condition? _____

   When? _____

   Treating physician: _____

3. Pacemaker: Yes _____ No _____

   For what condition? _____

   When? _____

   Treating physician: _____

4. By-pass surgery: Yes _____ No _____

   For what condition? _____

   When? _____

   Treating physician: _____

5. Vascular surgery: Yes _____ No _____

   For what condition? _____

   When? _____

   Treating physician: _____

6. Any other surgery: Yes _____ No _____

For what condition? _____

When? _____

Treating physician: _____

IX. USE OF HT MEDICATIONS

Please complete the following chart with respect to each HT medication you recall taking during the period beginning ten (10) years before your injury through to the present.

Answer:

Plaintiff refers Defendants to her pharmacy records and the records of her prescribing physicians which describe in greater detail her use of hormone therapy. To the best of Plaintiff's recollection, Plaintiff used the following hormone therapy drugs:

Generic Name	Brand Name	Description	Approximate Dates of First and Last Use	Prescribed by	Manufacturer or Drug Company and NDC No.	Condition(s) for which HT medication was prescribed

XI. THE INJURY

A. On what date and time did you first experience any symptoms you believe are related to the injury/ies alleged in your Complaint? (If you are claiming more than one injury, please copy this page and fill out for each injury.)

_____

B. In what city and state were you when you experienced those symptoms?

_____

C. Were there any witnesses to the symptoms identified above? If so, state their name, addresses, phone numbers and relationship to you.

_____

_____

_____

D. When did you first contact a doctor or healthcare professional concerning this injury?

_____

E. Who was the first such contact?

_____

_____

XII. INJURY CLAIMS

1. Have you had discussions with any physician(s) about whether your condition is related to the use of HT medications? Yes _____ No _____ Don't know _____

   If yes, please identify: Name of doctor: _____

   Address: _____

   Specialty: _____ Date of discussion: _____

   and, check one of the following:

   1. _____ I was told my condition is related to the use of HT medications.
   2. _____ I was told my condition is not related to the use of HT medications.
   3. _____ I was told my condition may be related to the use of HT medications
   4. _____ I was told by the doctor that he or she does not know whether my condition is related to the use of HT medications.
   5. _____ I don't recall what I was told.
   6. _____ Other: (describe discussion regarding HT medications)

      _____

   (If discussed with more than one doctor, please copy and complete Question 1 for each)

2. **Lost earnings** - If you claim or expect to claim that you lost earnings or suffered impairment of earnings capacity as a result of any condition that you believe was caused by your HT medication, complete the following information with respect to your employment for the period beginning five (5) years before your injury through to the present.

Employer	Address	Type of Business/Position	Dates of Employment	Salary

State the total amount of time which you have lost from work as a result of any condition which you claim was caused by your use of HT medications and the amount of income which you lost.

_____

_____

State your earned income for each of the past five years.

Year ***Income***

_____ $_____

_____ $_____

_____ $_____

_____ $_____

_____ $_____

3. **Medical Expenses -** Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim was caused by your use of HT medications for which you seek recovery in the action which you have filed? Yes _____ No _____

If yes, please state the total amount of such expenses at this time.

$ _____

Plaintiff also refers Defendant to Plaintiffs' medical bills for a detailed and accurate accounting of all medical expenses.

4. Fact witnesses - Please identify all persons who you believe possess information concerning your injury and/or your current medical conditions and for each, state their name, address, telephone number and a description of the information you believe they possess.

1. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Information they possess: _____

_____

2. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Information they possess: _____

_____

3. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Information they possess: _____

_____

4. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Information they possess: _____

_____

VERIFICATION

I,_____, declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief and that I have supplied all the documents requested in Part XIII of this Plaintiff's Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have signed and supplied the authorizations attached to this Verification.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Signature Date

XIII. DOCUMENTS

The judge requires you to provide a copy of any of the following documents that you have in your possession. I have tried to give you an explanation for each item and what materials are specifically being requested. Note that you are not supposed to create materials but merely provide a copy of documents if they are in your current possession.

1. **Authorizations -** Please sign and attach to this Fact Sheet the authorizations for the release of records appended hereto.

   Notes: You must sign the attached HIPAA Medical Authorization which permits the drug companies to get copies of your medical records. You have already signed a similar document for our office but this authorization is specifically for the drug companies. THIS DOCUMENT MUST BE RETURNED WITH YOUR PAPERWORK.

2. **Documents in your possession -** If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.

   A. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

      Notes: If you have any documents from a compensation or disability claim, please send us copies of those materials.

   B. All diagnostic tests or test results including original films or video of ultrasounds, mammograms, x-rays, echocardiograms, angiograms, CT-scans, MRIs, MRAs or electroencephalograms taken since five (5) years before you started taking hormone therapy OR since ten (10) years before the occurrence of the earliest injury you complain of in this lawsuit, whichever date is earlier.

      Notes: If you have actual copies of mammogram films or a videotape of an echocardiogram, you must send us those materials.

   C. Copies of all documents from physicians, healthcare providers or others relating to the use of HT medications, or to any condition you claim is related to the use of HT medications.

      Notes: If you have documents from any of your doctors which refer to or detail hormone therapy or your use of such medications, please provide those materials to us.

   D. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of HT medications.

      Notes: This request asks for copies of any materials that you got from your doctor or the pharmacy which contain warnings or instructions about hormone therapy drugs. This would include the white typed document that is often stapled to your pharmacy bag when you pick up your prescription or any printed information about hormone therapy drugs that any doctor gave to you.

E. Copies of advertisements or promotions for HT medications and articles discussing menopause or hormone therapy.

Notes: This request asks for actual copies of ads for hormone therapy drugs. If you saved copies of any such advertisement from a magazine or journal, please provide us with these documents.

F. Copies of the entire packaging, including the bottle, box and label for the HT medication you allege caused you injury and any remaining medication. (Plaintiffs must maintain the originals of the items requested in this subpart.)

Notes: This request asks you to provide any unused pills in your possession. Please check your medicine cabinet. If you still have an old bottle with left over hormone therapy pills or old sample packs, please send it to us.

G. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

Notes: It is unlikely that you have any documents responsive to this request because it asks for actual written statements of a fact witness about your injuries. However, if you have a statement that meets this description, please send it to us.

H. All documents relating to your purchase of HT medications, including, but not limited to, receipts, prescriptions or records of purchase.

Notes: If you have copies of receipts, invoices, cancelled checks, credit card statements or materials which show how much you paid for your hormone therapy medications, please provide those to us.

I. All documents known to you and in your possession which mention HT or any alleged health risks or hazards related to HT in your possession at or before the time of the injury alleged in your Complaint.

Notes: This request is for any documents that you had BEFORE you got injured which mention hormone therapy or its risks

J. All documents in your possession which you believe were provided to you (not to your lawyer) by any defendant.

Notes: This request asks for any document that you received from any of the drug companies that made hormone therapy. So, if you ever wrote to Wyeth or Pharmacia and received a reply, you should provide us with a copy of that document.

K. All photographs, drawings, journals, slides or videos relating to your alleged injury or your life after the incident.

Notes: This request asks for photographic evidence of your injuries. It is VERY important that we provide this documentation. If you had breast cancer, and have any residual breast disfigurement (including unevenness in size or shape, mastectomy or

lumpectomy scars, loss of nipple etc.), we need you to take a photograph of those injuries. You should stand before a blank background or pale colored wall and take a photograph of yourself from the neck down and with the camera focused on your breast area. You do not have to include your face in the picture. You should write your name and the date of the picture on the back of the photograph. You can use a regular camera, an instant camera or a digital camera and email us the photographs.

L. Copies of all documents you (and not your lawyer) obtained from any source related to HT or to the alleged effects of ingesting HT products or medications.

Notes: This request includes any printed materials that you got from the internet, your own research or any documents which talk about hormone therapy drugs.

M. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the last five (5) years.

Notes: If you were employed at the time of your injury, you should send us a copy of your federal income tax returns for each year from 1998 to 2003. If you do not have copies of those at your home, you should get copies from your accountant or tax advisor. This request should not be ignored just because you do not have a copy of the tax return actually in your home. You are obligated to get copies from your agent (which includes any tax form preparers).

N. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

Notes: If you have any bills, invoices, insurance payments or such medical expense information, you should provide that information.

O. Copies of letters testamentary or letters of administration relating to your status as plaintiff.

P. Decedent's death certificate and autopsy report (if applicable).

Notes: If you are representing a deceased claimant, we will need legal proof of your ability to represent the decedent as well as a copy of the death certificate or autopsy report.

Q. All journals, diaries, notes, letters, emails or other documents written by you or received by you which refer to your health or well-being, including any injuries or illnesses, or which refer to hormone therapy products or the risks or benefits of hormone therapy.

Notes: This request does NOT ask for all of your diaries or calendars. It only asks for materials which refer to hormone therapy products. So do not send us every calendar from your refrigerator. But do send us any notes or journal entries that you have which refer to hormone therapy.

Full Name: _____

Social Security Number: _____

Date of Birth: _____

IN RE: PREMPRO PRODUCTS LIABILITY LITIGATION
MDL *1507* (E.D. **Ark.)**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
In compliance with HIPAA, 45 CFR § 164.508

To:

Name of Entity: _____

Address: _____

City, State and Zip Code: _____

You are hereby authorized to release my entire medical records file to the defendant or its authorized representative listed below ("Record Requestor"). This release authorized you to furnish copies of all medical records, including, but not limited to medical reports and notes, laboratory reports, pathology slides, reports, notes and specimens, radiographic films, CT scans, X-rays, MRI films, MRA films, correspondence, progress notes, prescription records, echocardiographic recordings, written statements, employment records, wage records, insurance, Medicaid, Medicare, and disability records, and medical bills regarding my injuries, diseases, diagnoses, or treatment, specifically including but not limited to III V/AIDS testing or treatment, drug testing, drug or alcohol abuse treatment, marriage or family counseling, as well as psychological/psychiatric treatment, notes and evaluations. Please note that this authorization is not limited in any way to the records or treatments specified above.

This authorization does not permit you to disclose anything other than documents and records to anyone.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. You are hereby authorized to release these records to the following Record Requestor for their use in the above-entitled litigation. The defendants have agreed to pay reasonable charges to supply copies of such records. All documents should be provided to:

(Records Requestor)

Williams & Connolly LLP (or its designee)

725 Twelfth Street, N.W.

Washington D.C. 20005

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time. Further, I hereby agree that a photostatic copy of this authorization may serve as an original.

This authorization shall not be valid unless the Records Requestor named above has executed the acknowledgement at the bottom of this authorization.

I understand that this authorization pertains directly to the civil litigation referenced above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including, but not limited to the resolution of any and all appeals.

I understand that any documents or records released by you could potentially be redisclosed by the aforementioned Records Requestor, and that any information re-disclosed by that party is not subject to this authorization or the regulations imposed by 45 CFR § 164.508.

I understand that I have the right to revoke this authorization at any time by providing to you a written revocation stating my intentions, and if I do exercise such revocation, I agree to simultaneously provide a copy of such revocation to the Records Requestor. I also understand that any revocation of this authorization shall not affect any disclosures that were made prior to my written revocation.

This authorization is executed and served in compliance with the Federal Regulations governing the release of private health information as outlined under 45 CFR § 164.508.

_____ Date: _____
Claimant, Guardian or Personal Representative Signature

_____
Description of the Guardian's or Personal Representative's Authority to Act for the Claimant.

_____ Date: _____
Witness Signature

Acknowledgement:

_____
Records Requestor Signature