Attorney Name(s) or Party without Attorney
Firm Name
Firm Address
City, State, Zip Code
Phone Number(s)
Fax Number
Email Address

Attorney for (Name) or Self-Represented

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

PLAINTIFF'S NAME, Plaintiff, vs. DEFENDANT'S NAME, Defendant	Case Number: **ASBESTOS – EXHIBITS I ASBESTOS FORMS**

EXHIBITS
I-1 to I-13

EXHIBIT I - 1
AUTHORIZATION FOR MEDICAL RECORDS

HIPAA COMPLIANT AUTHORIZATION FOR MEDICAL RECORDS PURSUANT TO 45 CFR 164.508

TO: _____
_____
_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, any and all medical information including but not limited to charts, records, reports, histories, laboratory studies, notes, x-rays and/or outpatient records, all chest x-rays, CT scans, cytology, pathology (including all slides and paraffin blocks) and PFT data and printouts pertaining to: Patient Name: _____;
Date of Birth _____; Social Security Number: _____; for purposes of review, evaluation and evidence in connection with a lawsuit filed on _____.

I acknowledge the right to revoke this authorization by writing to the ROA Agent at RecordTrak at 130 Webster Street, Suite # I00, Oakland, CA 94607. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization is given in compliance with the Federal Confidentiality Law (21 U.S.C. Section 1175, 42 CFR Subsection 2.1-2.67.1 and Health & Safety Code Section 199.21(g) and California Civil Code Section 56, et seq.) and specifically allows you to release alcohol, drug, psychiatric, sickle cell anemia information and/or HIV test results which are not unequivocally negative.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.

This authorization is effective immediately and shall remain in effect for one year. I understand that I have a right to receive a copy of this authorization upon request.

Copy requested and received: [ ] Yes [ ] No Initials: _____

It is also my understanding that RECORDTRAK is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, or a motion for preference has been filed, the first look is 7 days.

Dated: _____ _____

The language of this authorization has been authorized by San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed Motion.

EXHIBIT I - 2
AUTHORIZATION FOR MEDICAL BILLS

HIPAA COMPLIANT AUTHORIZATION FOR BILLING RECORDS PURSUANT TO 45 CFR 164.508

TO: _____
_____
_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, in connection with a legal claim, the following information for any time whatsoever pertaining to the following patient for purposes of review, evaluation and evidence in connection with a lawsuit filed on _____. Patient Name: _____; Date of Birth _____; Social Security Number:_____.

As used in this Authorization, "DOCUMENTS" means a writing, as defined in evidence Code Section 250, and includes the original or a copy without limitation of every kind of written, printed, typed, recorded, or graphic matter, however produced or reproduced, including but not limited to notes, forms, claims, memoranda, briefs, summaries, charts, medical records, transcripts and correspondence concerning or relating to the individual referenced above.

- Any and all billing records and statements which relate or pertain to any treatment, service, payment, credit, adjustment, or transaction of any type.
- Any and all documents reflecting payments made by Medicare, MediCal, Medicaid and/or any other medical insurance.
- Any and all documents reflecting any payments made by the patient on his/her own behalf.
- Any and all documents reflecting the medical charges to date and the current balance of the account.
- Any and all documents reflecting the total cost of each of the patient's medical treatments at the said facility, and the breakdown of the amount actually paid by and/or due from each payee, including but not limited to the patient, Medicare, MediCal, Medicaid and/or any other medical insurance.
- Any and all documents showing the amount discounted/reduced by your facility or its contracting agency from the total medical charges.
- Any and all contracts between Medicare, MediCal, Medicaid and your facility or contracting agency, physicians, employees and/or any other agents or representatives of your facility.
- Any and all documents contained in completed UB-92 or HFCA 1500 forms, such as ICD-9 diagnosis and procedure codes, including any E-codes, CPT codes, and DRG codes. Payment documentation should include explanations of reviews and/or explanations of benefit forms detailing the payments accepted for services provided to the patient. Any and all documents entitled CMS or Medicare Summary Notice.

This authorization is given in compliance with the Federal Confidentiality Law (21 U.S.C. Section 1175, 42 CFR Subsection2.12.67.1 and Health and Safety Code Section 199.21(g) and California Civil Code Section 56 et seq.) and specifically allows you to release alcohol, drug, psychiatric, sickle cell anemia information and/or HIV test results which are not unequivocally negative. This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. {552 a(b)) and the California Confidentiality of Medical Information Act (C.C. Subsection 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. This authorization is effective immediately and shall remain in effect for 1 year. I understand that I have a right to receive a copy of this authorization upon request. Copy requested and received: Yes No Initials: _____

It is also my understanding that RECORDTRAK is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, or a motion for preference has been filed, the first look is 7 days.

I acknowledge the right to revoke this authorization by notifying the record custodian in writing at the facility identified above of my desire to revoke it. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508.
I understand that the covered entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

Signature: _____ Date: _____

The language of this authorization has been authorized by San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed Motion.

EXHIBIT I - 3
AUTHORIZATION FOR EMPLOYMENT RECORDS

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, any and all employment records including but not limited to employment applications, personnel files, job descriptions and assignments, performance evaluations, attendance records, correspondence, wage and salary information, medical records and medical bills, accident reports, compensation and disability claims, insurance coverage information, pension records, and any and all employee benefits pertaining to _____; Date of Birth _____; Social Security Number: _____; for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived.

A photocopy of this authorization shall be valid as the original. This authorization is effective immediately and shall remain in effect for one year.

I understand that I have a right to receive a copy of this authorization upon request.
Copy requested and received: Yes No Initials: _____

It is also my understanding that RECORDTRAK is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, or a motion for preference has been filed, the first look is 7 days.

Date: _____ _____

The language of this authorization has been authorized by San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

EXHIBIT I - 4
AUTHORIZATION FOR UNION/HEALTH & WELFARE RECORDS

AUTHORIZATION FOR RELEASE OF UNION/HEALTH & WELFARE RECORDS

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, any and all union records including but not limited to union dues statements, membership records, dispatch slips, employers and employment sites, beneficiary records, health and welfare trust records, pension records, accident reports, compensation and disability claims, medical records and medical bills, union literature regarding health and safety procedures and writings reflecting meetings on health and safety issues pertaining to _____; Date of Birth _____; Social Security Number: _____; for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.
This authorization is effective immediately and shall remain in effect for one year.

I understand that I have a right to receive a copy of this authorization upon request.
Copy requested and received: Yes No Initials: _____
It is also my understanding that RECORDTRAK is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, or a motion for preference has been filed, the first look is 7 days.

Date: _____ _____

The language of this authorization has been authorized by San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

EXHIBIT I - 5
AUTHORIZATION FOR DEATH CERTIFICATE

AUTHORIZATION FOR RELEASE OF DEATH CERTIFICATE

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, the **Death Certificate** pertaining to _____;
Date of Birth _____; Date of Death _____;
Social Security Number: _____; for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.
This authorization is effective immediately and shall remain in effect for one year.

I understand that I have a right to receive a copy of this authorization upon request.
Copy requested and received: Yes No Initials:_____

It is also my understanding that RECORDTRAK is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, or a motion for preference has been filed, the first look is 7 days.

Date: _____ _____

The language of this authorization has been authorized by San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

EXHIBIT I - 6
AUTHORIZATION FOR FUNERAL RECORDS

AUTHORIZATION FOR RELEASE OF FUNERAL RECORDS

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, any and all **Funeral records** pertaining to:
_____; Date of Birth _____;
Date of Death _____; Social Security Number: _____; for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.
This authorization is effective immediately and shall remain in effect for one year.

I understand that I have a right to receive a copy of this authorization upon request.
Copy requested and received: Yes No Initials: _____
It is also my understanding that RECORDTRAK is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, or a motion for preference has been filed, the first look is 7 days.

Date: _____ _____

The language of this authorization has been authorized by San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

EXHIBIT I - 7
AUTHORIZATION FOR SOCIAL SECURITY EARNINGS RECORDS

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) - - One SSN per request

Date of Birth: / / Date of Death: / /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☒ **Itemized Statement of Earnings $136**
(Includes the names and addresses of employers)

If you check this box, tell us why you need this information below.

LITIGATION

Year(s) Requested: to
Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $56.00 fee.

☐ **Certified Yearly Totals of Earnings $56**
(Does not include the names and addresses of employers)
Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name RECORDTRAK

Address 130 WEBSTER STREET, SUITE 100 State CA

City OAKLAND ZIP Code 94607

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

Signature AND Printed Name of Individual or Legal Guardian

SSA must receive this form within 120 days from the date signed

Date: / /

Relationship (if applicable, you must attach proof) Daytime Phone:

Address State

City ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (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)*

EXHIBIT I - 8
AUTHORIZATION FOR SOCIAL SECURITY DISABILITY RECORDS

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field)*.

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:	*ADDRESS OF PERSON OR ORGANIZATION:
RECORDTRAK	130 WEBSTER STREET, SUITE 100
*SEE BELOW	OAKLAND, CA 94607

***I want this information released because:** _____

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

This authorization is effective immediately and shall remain in effect for one year. RecordTrak is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference or a motion for preference has been filed, the first look is 7 days. The language of this authorization has been authorized by the San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

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

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ 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 _____
5. ☒ My Medicare entitlement from date _____ to date _____
6. ☒ Medical records from my claims folder(s) from date_____ to date_____

   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 **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   Any and all medical records, applications, questionnaires, consultative examinations, reports, determinations, etc.

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 any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain 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:** _____

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 SSA-3288 (07-2013) EF (07-2013)

EXHIBIT I - 9
STIPULATION FOR MILITARY RECORDS

BERRY & BERRY
A Professional Law Corporation
2930 Lakeshore Avenue
Oakland, California 94610
Telephone: (510) 250-0200

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE CITY AND COUNTY OF SAN FRANCISCO

No. _____

Plaintiff (s),

STIPULATION RE RELEASE OF RECORDS AND ORDER

vs.

Defendant(s) /

Plaintiff above named and all defendants do hereby stipulate and agree to entry of an order of this Court compelling release of all records in the possession, custody and/ or control of the Custodian of Records, National Personnel Records Center, St. Louis, Missouri, including but not limited to, medical, employment, workers' compensation and military records pertaining to: _____; Place of Birth: _____; Employed at: _____; from:_____; Government Serial No.: _____ ; Branch of Military Service: _____: from: _____; Military Serial Number: _____.

The Federal Privacy Act has been specifically considered in entering this stipulation.

It is further stipulated that all records be released directly to RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607 for copying, without the necessity of a formal motion and that **RECORDTRAK** is required by court order to send any records they obtain to plaintiff's counsel for a 21 day first look before sending them to any defendant. If the

preliminary fact sheet indicates plaintiff will seek trial preference, or in cases where a motion has been filed, the first look is 7 days.

Dated: _____ By_____

Attorney for Plaintiff

Dated: _____ BERRY & BERRY
A Professional Corporation

By_____
Evanthia M. Spanos, Esq.
Designated Defense Counsel

BERRY & BERRY
A Professional Law Corporation
2930 Lakeshore Avenue
Oakland, California 94610
Telephone: (510) 250-0200

ORDER

IT IS HEREBY ORDERED that the custodian of Records, National Personnel Records Center, St. Louis, Missouri, produce all records in his possession, custody and/or control pertaining to _____ ,including but not limited to, medical, employment, and Workers' Compensation records, all pursuant to 5 U.S.C. Section 522a(b)11. The Federal Privacy Act has been specifically considered in ordering the release of these records and this order is made pursuant to that Act.

IT IS FURTHER ORDERED that the records be released directly to **RECORDTRAK**, and that the copies of any records received will be provided to plaintiff's counsel for a 21 day first look before sending them to any defendant. If the preliminary fact sheet indicates plaintiff will seek trial preference, or in cases where a motion for preference has been filed, the first look is 7 days.

Dated:_____ _____

Judge of the Superior Court

The language of this stipulation has been authorized by the San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

EXHIBIT I – 10
AUTHORIZATION FOR MILITARY RECORDS

Standard Form 180 (Rev. 5/12) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))

Authorized for local reproduction
Previous edition unusable

OMB No. 3095-0029 Expires 01/31/2015

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/*

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☒ **DD Form 214 or equivalent.** When was the DD Form(s) 214 issued? YEAR(S): _____
If more than one period of service was performed, even in the same branch, there may be more than one DD214.

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

An undeleted copy will be sent unless you specify a deleted copy. Indicate here if you want a deleted copy of the DD Form 214 . ☐.

The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☒ **All Documents in Official Military Personnel File (OMPF)**

☒ **Medical Records** (Includes Service Treatment Records, Health (outpatient) and dental records.) If hospitalized (inpatient), the facility name and date for each admission **must** be provided: _____

☒ **Other** (Specify): Disability Records

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain: **LEGAL**

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: *(Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.) No signature required for Archival records.*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran: _____ *(Relationship)*
☐ Legal guardian (Must submit copy of court appointment.)
☐ Other (specify) _____

MUST HAVE PROOF OF DEATH - See item 2a on instruction sheet.

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

RECORDTRAK
Name

130 WEBSTER STREET, SUITE 100
Street Apt.

OAKLAND, CA 94607
City State Zip Code

3. AUTHORIZATION SIGNATURE WHEN REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct. No signature required for Archival records.

Signature Required - Do not print **Date**

( ) ( )
Daytime phone Fax Number

Email address

This authorization is effective immediately and shall remain in effect for one year. RecordTrak is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference or a motion for preference has been filed, the first look is 7 days. The language of this authorization has been authorized by the San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

EXHIBIT I – 11
AUTHORIZATION FOR MEDICAL RECORDS FROM MILITARY FACILITIES

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	[ ] OUTPATIENT [ ] INPATIENT [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
RECORDTRAK	130 Webster Street, Suite 100 Oakland, CA 94607
c. TELEPHONE *(Include Area Code)* (510) 465-3200	d. FAX *(Include Area Code)* (510) 465-3652

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [ ] OTHER *(Specify)*
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [X] LEGAL

8. INFORMATION TO BE RELEASED
All medical records, films, pathology and/or cytology materials, billing and payment information, Medicare & Medical payments
from _____ to _____

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	
	[ ]	[X] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

This authorization is effective immediately and shall remain in effect for one year. RecordTrak is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference or a motion for preference has been filed, the first look is 7 days. The language of this authorization has been authorized by the San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

SFCIV-030
Rev: Jun-29-2012

EXHIBIT I – 12
AUTHORIZATION FOR VETERAN'S MEDICAL RECORDS

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

RECORDTRAK, 130 WEBSTER STREET, #100, OAKLAND, CA 94607
PHONE: (800) 220-3200 FAX: (510) 465-3200

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Include all medical records, films, pathology and/or cytology materials, paraffin blocks and slides, billing and payment information, Medicare & MediCal payments from _____ to_____.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

ASBESTOS LITIGATION

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on One Year (date supplied by patient); (3) under the following condition(s):

This authorization is effective immediately and shall remain in effect for one year. RecordTrak is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference or a motion for preference has been filed, the first look is 7 days. The language of this authorization has been authorized by the San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM JUL 2013 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.

SFCIV-030
Rev: Jun-29-2012

EXHIBIT I - 13
AUTHORIZATIONS FOR VETERAN'S DISABILITY CLAIMS RECORDS

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

RECORDTRAK, 130 WEBSTER STREET, #100, OAKLAND, CA 94607
PHONE: (800) 220-3200 FAX: (510) 465-3200

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☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Any and all records including but not limited to disability claims,medical records & bills, pension records, veteran benefits, Medicare & MediCal payments,reimbursements & inquiries.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

ASBESTOS LITIGATION

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on One Year (date supplied by patient); (3) under the following condition(s):

This authorization is effective immediately and shall remain in effect for one year. RecordTrak is required by court order to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference or a motion for preference has been filed, the first look is 7 days. The language of this authorization has been authorized by the San Francisco Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without order of the San Francisco Superior Court on noticed motion.

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM JUL 2013 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.