AUTHORIZATION AND RELEASE
FOR EMPLOYMENT RECORDS

Name and address of the employer authorized to make the requested disclosure:

Name: _____
Address: _____
_____
_____

Employee name: _____ Date of Birth: _____
Social Security Number: _____

I authorize all holders of **employment records** to furnish copies of any and all recorded information, including by way of example, but not limited to the following:

> all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, disciplinary records, workers' compensation files; all hospital, physician, clinic, infirmary, nurse, psychiatric and dental records; x-rays, test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; reasons for termination or leaving; and any other records concerning employment with the above-named institution, including records for treatment of psychological, psychiatric or emotional problems.

I authorize you to release the protected employment records to the following, who have agreed to pay reasonable charges made by you to supply copies of such records:

Catherine B. Stevens
Quinn Emanuel Urquhart & Sullivan, LLP
51 Madison Avenue, 22nd Floor
New York, NY 10010

RecordTrak
651 Allendale Road
P.O. Box 61591
King of Prussia, PA 19406

I acknowledge the right to revoke this authorization by writing to the attorney at the above-referenced address. 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 redisclosure by the recipient and no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization remains in effect for the duration of my litigation involving Pfizer Inc.

_____ _____
Signature of Employee Dated

_____
Name of Employee