HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508

Name and address of the person or provider authorized to make the requested disclosure:

Provider: _____
Address: _____
_____
_____

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

I authorize the disclosure of all protected **medical and/or insurance** information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information, including the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, phone notes, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and letters or records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac, catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.
- All records of any samples of prescription medicines provided.
- This authorization applies to psychotherapy notes, and psychiatric or psychological records.
- Information regarding HIV/AIDS and/or substance abuse may be disclosed.

I authorize you to release the protected health information 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 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 remains in effect for the duration of my litigation involving Pfizer Inc.

_____ _____
Signature of Patient or Personal Representative Dated

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Patient