AUTHORIZATION AND RELEASE
FOR INSURANCE RECORDS AND REPORTS

Name and address of the insurance company or entity authorized to make the requested disclosure:

Name: _____
Address: _____
_____
_____

Insured's Name: _____ Date of Birth: _____
Social Security Number: _____

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

> all applications for insurance coverage and renewals; insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; physician, hospital, psychiatric, psychological, and dental reports, prescriptions, correspondence, test results, radiological films and any other medical records submitted for claims review purposes; claims records; records of all litigation; and all other records of any kind concerning or pertaining to the Insured.

I authorize you to release the protected insurance records and reports 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 Insured or Personal Representative Dated

_____
Name of Insured or Personal Representative

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