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-14

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 EARNING 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
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 $100.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

ASBESTOS LITIGATION

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

☒ Check this box if you want the earnings information **CERTIFIED** for an additional $44.00 fee.

☐ **Certified Yearly Totals of Earnings $44.00**
(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 declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

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

Address *(Number and Street, City, State and ZIP Code)*

2. Signature of Witness

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. **Please complete these fields in case we need to contact you about the consent form).*

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:** Asbestos Litigation

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

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of 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 (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   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 it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining 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:** _____ ****Daytime Phone:** _____

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)

EXHIBIT I - 9
AUTHORIZATION FOR MEDICARE RECORDS

MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:

Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:

Address:

City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:
- ☐ Release **all** records to date
- ☒ Release records in timeframe from start date _____ to end date: _____

NY residents only:
- ☐ Include all records
- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or Identify a future date or event when the authorization will expire.

Select **one** option:
- ☐ One-time disclosure
- ☐ Expiration upon specified date _____
- ☒ Expiration upon specified event 1 year from date of execution

SECTION C: RELEASE INFORMATION TO

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name	Recipient 1 Email Address
Recordtrak .	recordtrakcaasbestosteam@magnals.com

Recipient 1 Mailing Address:

130 Webster Street, Suite 100 Oakland, CA 94607

SECTION D: PURPOSE FOR REQUEST

This section helps Medicare understand the reason or intent for use for this record request.

At the request of the individual	▪ Litigation

SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law:	Date Signed:

Legal Role of Representative (Requires Additional Documentation):

It is also my understanding that RECORDTRAK is required by law 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, the first look is 7 days.

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.

EXHIBIT I – 12
AUTHORIZATION FOR VETERAN'S MEDICAL RECORDS

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is 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 the instructions, gather the necessary facts and fill out this form. 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 information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

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

Recordtrak, 130 Webster Street, Suite 100, Oakland, CA 94607 (800) 220-3200

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY *(Prior 2 Years)*

☒ PATIENT MEDICAL RECORDS *(Dates)*: Dates needed noted below

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*:

☒ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*:
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
- ☒ DATE RANGE: Dates needed noted below

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*:

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*:
- ☐ DATE RANGE:

☒ RADIOLOGY REPORTS *(Name & Date)*: Dates needed noted below

☒ LIST OF ACTIVE MEDICATIONS:

☒ VACCINATION *(Dose, Lot Number, Date & Location)*:

☐ ADMINISTRATIVE RECORDS:

☒ OTHER *(Describe)*: All medical records, films, pathology, and/or cytology materials, paraffin blocks and slides, billing and payment information, Medicare & MediCal payments from _____to_____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

[X] DRUG ABUSE [X] ALCOHOLISM OR ALCOHOL ABUSE [X] SICKLE CELL ANEMIA

[X] HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

[ ] **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider'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.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

[ ] AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

[X] ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

[ ] UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

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

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is 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 the instructions, gather the necessary facts and fill out this form. 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 information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

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

Recordtrak, 130 Webster Street, Suite 100, Oakland, CA, 94607

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY *(Prior 2 Years)*

☒ PATIENT MEDICAL RECORDS *(Dates)*: All hospital summary and outpatient treatment notes

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*:

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*:
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
- ☐ DATE RANGE:

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*:

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*:
- ☐ DATE RANGE:

☐ RADIOLOGY REPORTS *(Name & Date)*:

☐ LIST OF ACTIVE MEDICATIONS:

☐ VACCINATION *(Dose, Lot Number, Date & Location)*:

☐ ADMINISTRATIVE RECORDS:

☒ OTHER *(Describe)*: **Any & all records including but not limited to disability claims, medical records & bills, pension records, vererans benefits, Medicare & medical payments, reimbursements & inquiries from _____ to _____**

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ SICKLE CELL ANEMIA

☒ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider'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.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): **One year from date of execution**

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

EXHIBIT I - 14
VA AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

OMB Approved No. 2900-0736
Respondent Burden: 5 minutes
Expiration Date: 04/30/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs (VA) permission to release your personal beneficiary or claim information to a third party. This form ***may not be executed*** by any beneficiary recognized as incompetent for VA purposes, nor can VA ***accept*** this form from any beneficiary recognized as incompetent for VA purposes.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may ***either*** complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly to expedite processing the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If known)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

6. NAME OF BENEFICIARY/CLAIMANT WHO IS ***NOT*** THE VETERAN *(First, Middle Initial, Last)*

7. ADDRESS OF BENEFICIARY/CLAIMANT *(Number and Street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

8. TELEPHONE NUMBER *(Include Area Code)*

Enter International Phone Number *(If applicable)*

9. EMAIL ADDRESS *(Optional)* ○ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III - CONTACT INFORMATION

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION SPECIFIED BELOW TO ONE PERSON ***OR*** ONE ORGANIZATION LISTED BELOW. PROVIDE THE NAME AND ADDRESS OF THE PERSON YOU HAVE CHOSEN TO RECEIVE INFORMATION FROM VA IN ITEMS 10A AND 10B ***OR*** PROVIDE THE NAME AND ADDRESS OF THE ORGANIZATION YOU HAVE CHOSEN AND THE NAME OF THE ORGANIZATION'S REPRESENTATIVE IN ITEMS 10C AND 10D.

A. NAME OF PERSON *(First, Middle Initial, Last Name)*

B. ADDRESS OF PERSON

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

NOTE: An organization may have more than one representative. Include the first and last name of any additional representatives.

C. NAME OF ORGANIZATION *(Include name of representative(s))*

RECORDTRAK

ALYSSA COMBS or NEIL CASTRO

VETERAN'S SSN [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

D. ADDRESS OF ORGANIZATION

No. & Street: 130 WEBSTER STREET

Apt./Unit Number: 100 City: OAKLAND

State/Province: CA Country: US ZIP Code/Postal Code: 94607 –

11. I, THE BENEFICIARY/CLAIMANT AUTHORIZE VA TO CONTACT THE PERSON ***OR*** ORGANIZATION LISTED IN ITEM 10A OR 10C FOR THE PURPOSE OF PROVIDING THE FOLLOWING INFORMATION PERTAINING TO MY VA RECORD *(Check only one box below to tell VA the specific benefit or claim information you want disclosed)*

○ LIMITED INFORMATION (Go to Item 12) ☒ ANY INFORMATION (Go to Item 13)

12. IF YOU SELECTED "LIMITED INFORMATION", FILL ALL THAT APPLY

○ Status of pending claim or appeal ○ Amount of money owed VA ○ Other (Specify below)

○ Current benefit and rate ○ Request a benefit payment letter

○ Payment history ○ Change of address or direct deposit

13. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

○ One time only ○ From the date of signing below until [ ][ ] – [ ][ ] – [ ][ ][ ][ ]
(Specify date - MM, DD, YYYY)

☒ Ongoing until written notice is given to VA to terminate

14. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY ***ONE*** SECURITY QUESTION BOX IN ITEM 14A AND PROVIDE THE ANSWER IN ITEM 14B.

A. SECURITY QUESTION	B. ANSWER
☒ The city and state your mother was born in	OAKLAND, CA
○ The name of the high school you attended	
○ Your first pet's name	
○ Your favorite teacher's name	
○ Your father's middle name	

SECTION IV - DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

15. VETERAN SIGNATURE (REQUIRED)

16. DATE SIGNED *(MM,DD,YYYY)* [ ][ ] – [ ][ ] – [ ][ ][ ][ ]

PRIVACY ACT INFORMATION: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain.** If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

1.560 oz 595114-002-0/3945029 0002879 0041697 I=000000