AUTHORIZATION

For the Disclosure of Protected Health Information Pursuant to 45 CFR § 164.508(a)(1)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This document authorizes you to disclose to the named party or parties below upon request, the medical records described below concerning _____, whose date of birth is _____ and whose social security number (last four digits) is _____, for the purpose of permitting defendants in my personal injury lawsuit against Covidien, LP, access to medical records pertinent to that lawsuit. This authorization does not allow any person other than my attorneys to discuss my medical care and treatment with you or anyone else.

You are hereby authorized to release my entire medical records file to the defendant or its authorized representative listed below ("Record Requestor"). This release authorizes you to furnish copies of all medical records, including but not limited to medical reports and notes, laboratory reports, pathology slides, reports, notes, and specimens, radiographic films, CT scans, X-rays, MRI films, MRA films, correspondence, progress notes, prescription records, echocardiographic recordings, written statements, employment records, wage records, insurance, Medicaid, Medicare, and disability records, and medical bills regarding my injuries, diseases, testing, or treatment, specifically but not limited to HIV/AIDS or other communicable diseases, drug testing, drug or alcohol abuse treatment, or mental or behavioral health or psychiatric care, **excluding psychotherapy notes**.

You may not condition treatment, payment, enrollment, or eligibility for benefits on whether this authorization is signed.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the requestor at that time.

Further, I hereby agree that a photo static copy of this authorization may serve as an original.

You are authorized to release the above information to the following representative of defendants in the above-entitled matter who has agreed to pay reasonable charges made by you to supply copies of records.

M R C
Name of Representative

Records Requestor
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

1336 Brittmoore Road, Suite 100
Street Address

Houston, Texas 77043
City, State and Zip Code

This authorization may be revoked by writing to the individual to whom this authorization is provided. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

I further acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by a recipient and not protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

This authorization expires two years from the date below.

Date: _____

_____
Signature or Patient (or Patient's Representative)

_____
Description of Representative's Authority to Act for Patient, if Applicable