**REQUEST AND AUTHORIZATION TO RELEASE**
**CONFIDENTIAL MEDICAL AND HEALTH CARE RECORDS**

I, the undersigned, do hereby request and authorize: to release the medical and healthcare records of:

_____ _____
NAME OF HEALTH CARE PROVIDER NAME OF PATIENT

_____ _____
ADDRESS PATIENT DATE OF BIRTH'

_____
CITY STATE ZIP

to the **CLAIMS COMMITTEE, c/o Anapol Schwartz, 1710 Spruce Street, Philadelphia, PA 19103**.

This request and authorization to release is made pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy Rule. This release is for any and all medical and healthcare records pertaining to the patient including but not limiting to: medical or psychological diagnoses, medical charts and notes, progress notes, treatment records, x-rays, photographs, films, test results, lab results, evaluations, admissions summaries, and discharge summaries, in the possession, custody or control of the Health Care Provider. The Health Care Provider shall accept a photocopy of this release in lieu of the original.

I understand that I have the right to revoke this release at any time by contacting the Health Care Provider, except that the revocation shall not be retroactive to the extent that the Health Care Provider has relied on it. I understand that the confidentiality of my records is protected by state and federal law. I understand that the information disclosed pursuant to this release may be subject to re-disclosure and may no longer be protected by these laws.

The release of these records to the CLAIMS COMMITTEE is for the sole purpose of processing my class action settlement claim. This release is valid for six (6) months from the date below.

I consent to this release of records. Please promptly send the records to the CLAIMS COMMITTEE at the address above.

_____ _____
Signature of Patient Date Signature of Parent/Guardian Date
(if patient 18 years of age or older) (if patient under 18 years of age)