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worker's compensation, or other disability claim identified in the Fact Sheet. The Fact Sheet and List of Medical Providers specify the persons or entities and time periods for which authorizations are to be provided. (A copy of General Order No, 5, including Exhibit "A" thereto (i.e. the Fact Sheet and List of Medical Providers), is attached hereto as Exhibit 2.) Defendants' use of the authorizations shall be in accordance with General Order No. 5, particularly Section C; and

3. All plaintiffs in diet drug cases filed in or transferred to this Court after the date of this Order shall use this approved form of authorization when complying with the existing requirements of this Court's General Order No. 5.

Dated: 8-11-2003

/S/  
-----  
Honorable Judge Daniel Solis Pratt  
Judge of the Superior Court

SUPERIOR COURT OF THE STATE OF CALIFORNIA  
COUNTY OF LOS ANGELES

**AUTHORIZATION FOR RELEASE OF RECORDS**

To: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State and Zip Code

This will authorize you to furnish copies of all medical records (exclusive of psychiatric and psychological records), reports, radiographic films, prescription records, echocardiographic recordings, written statements, employment records, education records, disability records, social security records, workers compensation records, medical bills, and other documents in your possession concerning:

\_\_\_\_\_  
Name of Patient

whose date of birth is \_\_\_\_\_ and whose social security number is \_\_\_\_\_, for the purpose of permitting defendants in an on-going lawsuit to obtain information pertinent to that lawsuit.

This authorization is not valid unless the Requestor named below has executed the acknowledgment at the bottom of this authorization. You may not condition treatment, payment, enrollment, or eligibility for benefits on whether this authorization is signed.

You are authorized to release the above records to the following representative of defendants who has agreed to pay reasonable charges made by you to supply copies of such records:

\_\_\_\_\_  
Name of Representative  
\_\_\_\_\_  
Representative Capacity (e.g. attorney, records requestor, agent, etc.)  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State and Zip Code

\* \* \*

This authorization may be revoked in writing (by mail, facsimile or personal delivery) 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.

Defendants intend to use the requested materials and documents solely for the purpose of litigation involving the Patient, and do not intend to re-disclose any of the materials or documents provided in response to this authorization, except in connection with their defense of the litigation. However, I do 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 one year from the date below.

This authorization does not authorize you to disclose anything other than documents and records to anyone.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient (or Patient's  
Representative)

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

#### ACKNOWLEDGMENT

The undersigned, as the requestor named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has received fifteen (15) days advance notice that the authorization will be used to request records from the person or entity to whom it is addressed and has been afforded an opportunity to object to the request for records and to order copies of the records requested from the undersigned requestor at a reasonable cost.

\_\_\_\_\_  
Requestor