SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER CASE NO. ATL-L-2122-18

IN RE PHYSIOMESH LITIGATION
(Flexible Composite Mesh)

CASE NO. 627
Civil Action

PLAINTIFF PROFILE FORM

In completing this Plaintiff Profile Form, you must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

I. CASE INFORMATION

Caption:_____ **Docket No.:** _____

Primary Attorney Contact (name, address, phone, and email):

_____

II. PLAINTIFF INFORMATION

Name of Individual with Physiomesh_____ ❑**Male** ❑**Female**

Date of birth:_____ **Last 4 Digits of Social Security No.:** _____

Address:_____

Occupation: _____

Spouse Name: _____ **Loss of Consortium Claim?** ❑**Yes** ❑**No**

Name of Estate Representative if Individual Implanted with Physiomesh is Deceased: _____

III. PHYSIOMESH FLEXIBLE COMPOSITE DEVICE & IMPLANT INFORMATION

Date of implant: _____

Reason You Believe Physiomesh was Implanted: _____

Lot Number: _____

Implanting Surgeon: _____

Medical Facility: _____

For each Physiomesh implant, submit the implant operative report and any medical evidence of product identification (product ID sticker).

Date of surgery: _____

Description of surgery: _____

Explanting surgeon: _____

Medical Facility: _____

Date of surgery: _____

Description of surgery: _____

Explanting surgeon: _____

Medical Facility: _____

For each removal/revision, submit the operative report, any pathology report, and any medical evidence identifying the product removed/revised.

***Attach additional pages as needed to identify other responsive implant or removal/revision procedures.

IV. OUTCOME ATTRIBUTED TO DEVICE

A. Describe in detail the injuries, including any emotional or psychological injuries, that you claim resulted from the implantation of Physiomesh:

B. Please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries listed above.

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

***Attach additional pages as needed to describe injuries or identify other responsive health care providers.

C. Other than the Physiomesh product(s) that is the subject of your lawsuit, have you ever been implanted with any other hernia mesh products? **[ ] Yes [ ] No.**

If Yes, please provide the following information:

1. Product Name(s) and Lot Numbers:

2. Date of implantation procedure(s) and name and address of implanting doctor(s):

**** Please submit all implant report(s) and product Identification Documentation for any implants listed in C. above.

D. Have you filed a lawsuit or asserted any claim related to any other hernia mesh products? ❑Yes ❑No ❑N/A

If Yes, identify the claim/lawsuit asserted, the court, docket number, the date the claim/lawsuit was made,: _____

E. If any other products listed in Sections C. or D. above have currently pending claims in **This Court**, please provide the following additional information:

1. Describe in detail the injuries, including any emotional or psychological injuries, that you claim resulted from the implantation of any other mesh product subject to claims in This Court:

2. Have any other products listed in Sections C. or D. above with claims currently pending in This Court been revised or removed? **[ ] Yes [ ] No.**

    a. If yes, identify when revised/removed and your understanding as to the reason for the revision/removal:

**** Please submit all operative report(s) and pathology records, if any, showing the removal or revision.

3. To the extent not already listed in Section B. above, please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries subject to claims in This Court:

Provider Name, Address, and Specialty	**Condition Treated**	**Approximate Dates of Treatment**

AUTHORIZATIONS AND MEDICAL RECORDS TO BE PRODUCED

Submit ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

Submit a copy of any medical records in your possession, custody, or control (including any medical records in your attorney's possession) related to the claims and/or alleged injuries in this case.

Signed this _____ day of _____ 20__

_____

Plaintiff's Counsel of Record
Firm Name
Firm Address
Firm Address 2
Phone
Email

AUTHORIZATION AND CONSENT
TO RELEASE RECORDS AND PROTECTED HEALTH INFORMATION
(Excluding psychotherapy notes)

Name of Individual:
Social Security Number:
Date of Birth:

Provider Name:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran s Administration and all Veteran s Administration hospitals, clinics, physicians and employees

The Social Security Administration

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to **Butler, Snow, O'Mara, Stevens & Cannada, PLLC, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, Texas 77040;** and their authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, dentists and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results, genetic testing information, and alcohol and drug abuse treatment) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all dental records, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic, hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

The undersigned also authorizes the disclosure of all records, reports, files, documents, correspondence, memoranda and all other information related to employment of the undersigned, including attendance reports, performance reports, W-2 and W-4 forms, medical reports and/or any and all other records relating to my past and present employment, and all educational records, including all courses taken, degrees obtained, and attendance records.

Further, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

The above list of types of records and other information to be disclosed is intended to be illustrative and not exhaustive. This authorization does not authorize ex parte communication concerning same.

This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ *v. Ethicon Inc., et al.*

The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice either to Butler, Snow, O'Mara, Stevens & Cannada, PLLC, Attention: Michael Brown, Butler Snow Privacy Officer, P.O. Box 6010, Ridgeland, Mississippi, 3915; Riker, Danzig, Scherer, Hyland & Perretti LLP, attention: Maha Kabbash, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102 and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

The undersigned is hereby notified and acknowledges he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler, Snow, O'Mara, Stevens & Cannada, PLLC; Riker, Danzig, Scherer, Hyland & Perretti LLP; McCarter & English; and/or The Marker Group, Inc., pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ *v. Ethicon Inc., et al* and is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for drug or alcohol abuse, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, Sickle Cell Anemia, Tuberculosis and Genetic testing and counseling.

I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of _____ **v. Ethicon Inc., et al. or (ii) five (5) years after the date of signature of the undersigned below.**

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Butler, Snow, O'Mara, Stevens & Cannada, PLLC, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 079621981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, Texas 77040; and/or and their authorized representatives, by any entities included in the categories listed above.

Date: _____

Individual's Name and Address:

_____

_____

_____

_____

Signature of Individual or Individual s Representative

_____

Printed Name of Individual s Representative (If applicable)

_____

Relationship of Representative to Individual (If applicable)

_____

Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

AUTHORIZATION AND CONSENT
TO RELEASE PSYCHOTHERAPY NOTES

Name of Individual:
Social Security Number:
Date of Birth:

Provider Name:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers
The Veteran s Administration and all Veteran s Administration hospitals, clinics, physicians and employees

The Social Security Administration

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to Butler, Snow, O'Mara, Stevens & Cannada, PLLC, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, Texas 77040; and their authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual s record. This authorization does not authorize ex parte communication concerning same.

This authorization provides for the disclosure of the above-named patient s protected health information for purposes of the following litigation matter: _____ *v. Ethicon Inc., et al.*

The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either Butler, Snow, O'Mara, Stevens & Cannada, PLLC, Attention: Michael Brown, Butler Snow Privacy Officer, P.O. Box 6010, Ridgeland, Mississippi, 3915, and/or Riker, Danzig, Scherer, Hyland & Perretti LLP, attention Maha Kabbash, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New

Jersey 07962-1981, McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102 and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler, Snow, O'Mara, Stevens & Cannada, PLLC , Riker, Danzig, Scherer, Hyland & Perretti LLP, McCarter & English, and/or The Marker Group, Inc. pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ *v. Ethicon Inc., et al.* and is subject to re-disclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of _____ v. Ethicon Inc., et al. or (ii) five (5) years after the date of signature of the undersigned below.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Butler, Snow, O'Mara, Stevens & Cannada, PLLC, P. O. Box 6010, Ridgeland, MS 39158; Riker, Danzig, Scherer, Hyland & Perretti LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, New Jersey 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, New Jersey 07102; and The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, Texas 77040 and their authorized representatives, by any entities included in the categories listed above.

Date: _____ _____

Signature of Individual or Individual s Representative

Individual's Name and Address: _____

Printed Name of Individual s Representative (If applicable)

_____ _____

Relationship of Representative to Individual (If applicable)

_____ _____

_____ _____

Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

Medicare

Beneficiary Services:1-800-MEDICARE (1-800-633-4227)
TTY/ TDD:1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.**

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Instructions for Completing Section 2B of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include**all information, in the space provided, write: "all information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude**the information listed above, write "Exclude information about alcohol and drug abuse, mental health treatment and HIV" in the space provided. *You may also check any of the remaining boxes and include any additional limitations in the space provided.*For example, you could write "payment information". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICAREAuthorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

   Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters (for example, 123456789A).

   Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2b that apply to the type of information you want Medicare to give out.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

5. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

   If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

7. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) _____ **Medicare Number** (Exactly as shown on the Medicare Card) _____ **Date of Birth** (mm/dd/yyyy) _____

2. Medicare will only disclose the personal health information you want disclosed.

   2A: **Check only one box below to tell Medicare the specific personal health information you want disclosed:**

   ☐ Limited Information (go to question 2b)

   ☐ Any Information (go to question 3)

   2B: **Complete only if you selected "limited information". Check all that apply:**

   ☐ Information about your Medicare eligibility

   ☐ Information about your Medicare claims

   ☐ Information about plan enrollment (e.g. drug or MA Plan)

   ☐ Information about premium payments

   ☐ Other Specific Information (please write below; for example, payment information)

   _____

3. **Check only onebox below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   ☐ Disclose my personal health information indefinitely

   ☐ Disclose my personal health information for a specified period only
   beginning: (mm/dd/yyyy)_____ and ending: (mm/dd/yyyy) _____

4. **Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:**

   1. Name: _____

      Address: _____

      _____

   2. Name: _____

      Address: _____

      _____

   3. Name: _____

      Address: _____

      _____

5. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may nolonger be protected by law.**

   _____ _____ _____

   Signature Telephone Number Date (mm/dd/yyyy)

   Print the address of the person with Medicare (Street Address, City, State, and ZIP)

   _____

   _____

   ☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This onlyapplies if someone other than the person with Medicare signed above.

   Print the Personal Representative's Address (Street Address, City, State, and ZIP)

   _____

   _____

   Telephone Number of Personal Representative: _____

   Personal Representative's Relationship to the Beneficiary: _____

6. **Send the completed, signed authorization to**:

Medicare BCC, Written Authorization
Dept.PO Box 1270
Lawrence, KS 66044

7. **Note:**

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0930**. The time required to complete this information collection is estimated to average **15 minutes**per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form **4506**

(July 2017)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ Do not sign this form unless all applicable lines have been completed.
▶ Request may be rejected if the form is incomplete or illegible.
▶ For more information about Form 4506, visit www.irs.gov/form4506.

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a Tax Return Transcript for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

6 Tax return requested. Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

_____ _____ _____ _____

_____ _____ _____ _____

8 Fee. There is a $50 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.

a Cost for each return . . . . . $

b Number of returns requested on line 7 . . . . .

c Total cost. Multiply line 8a by line 8b . . . . . $

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. Note: This form must be received by IRS within 120 days of the signature date.

☐ Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506. See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ Signature (see instructions) Date

▶ Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ Spouse's signature Date

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

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:**

***I want this information released because:**
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.)

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)