SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER DOCKET NO. ATL-L-794-19

MCL CASE NO. 630

Civil Action

IN RE PROCEED MESH LITIGATION
(Proceed® Surgical Mesh and Proceed® Ventral Patch Hernia Mesh)

CASE MANAGEMENT ORDER NO. 25
[Stempler Interviews and Authorizations]

This matter having been opened to the Court by counsel for the Defendants; and it appearing that certain treating physicians are independent fact witnesses in the within MCL; and good cause appearing as stated on the record;

IT IS on this 12th day of May, 2022,

ORDERED as follows:

1. Defendants are permitted to conduct *ex parte* interviews in accordance with Stempler v. Speidell, 100 N.J. 368 (1985), ("Stempler interview") with treating physicians who have engaged in *ex parte* substantive communications with any plaintiff's counsel.

2. In such cases, plaintiff is to execute and return to defendants within 10 days of request the form of authorization for such Stempler interview attached hereto as Exhibit A.

3. Defendants shall give Plaintiff's counsel reasonable notice of the time and place for any such interview, such that Plaintiff's counsel shall have an opportunity to communicate with the physician prior to the Stempler interview, in order to express any appropriate concerns as to the proper scope of the interview and the extent to which plaintiff continues to assert the patient-physician privilege with respect to that physician. Any such communication by plaintiff or plaintiff's counsel shall be in writing only and copied to defense counsel.

4. Plaintiffs and their attorneys shall **take no steps to interfere with or discourage the physician's participation**.

5. Defendants shall provide the physician with a description of the expected scope of the interview and indicate clearly that the doctor's participation is voluntary.

6. The conduct of a Stempler interview does not preclude a party from seeking a deposition pursuant to CMO 24 ¶ 4.

HON. JOHN C. PORTO, Acting P.J.Cv.

EXHIBIT A

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION AND FOR VOLUNTARY INTERVIEW

TO:

Re: Patient:_____
SS#: _____
DOB:

I authorize **Dr.** _____(the "Treating Physician") to disclose protected health information as specified below, and to participate in a voluntary interview with Defense counsel listed below.

YOUR PARTICIPATION IN ANY SUCH INTERVIEW IS ENTIRELY VOLUNTARY.

I understand that this Authorization is voluntary and that I am not required to sign this Authorization. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to the Treating Physician. I understand that I cannot revoke this Authorization to the extent that the Authorization has been relied upon. I understand that the information released pursuant to this Authorization may no longer be protected by law or regulation and may be redisclosed by the recipient.

I understand that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), HIPAA regulations, as well as other Federal and State laws and regulations, create a right of privacy that is associated with the records, information and data covered by this Authorization. Consistent with 45 CFR § 164.508, I expressly authorize you to discuss your treatment of Patient and Patient's records, information and data with representatives of the defense counsel listed at paragraph (3), below, as follows:

(1) **The information to be disclosed is as follows**: I expressly authorize representatives of the defense counsel listed in paragraph (3), below, to request and discuss with Treating Physician any and all of the above identified Patient's protected health information in your possession, including your treatment and care of, and all records, information and other data (regardless of how those items are identified) related to any and all care, treatment or services provided for the above identified Patient's physical health, mental health, or psycho-social health **(not including psychotherapy notes which are 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 medical record).** Throughout the remainder of this Authorization, I collectively refer to all of Patient's health information, records and data as the Protected Health Information ("PHI"). This Authorization is intended to be general, full and all encompassing so that the person(s) named in paragraph (3), below can access, without limitation, any and all PHI, **except the following information, unless the line next to each of these is initialed below: HIV/AIDS; drug and alcohol abuse; mental health/psychiatric; sexually transmitted diseases**. This Authorization applies to any and all PHI in your possession, under your control or to which you have access. The person(s) authorized in Paragraph (3), below, are further authorized to limit their request to portions of the identified PHI and may do so by letter to you, and they are authorized to conduct a voluntary *ex parte* interview with you regarding PHI. I expressly invoke the AMA Principles of Medical Ethics, as well as Canon E-9.07, as well as similar ethics principles that may apply to other health care disciplines.

_____ HIV/AIDS
_____ Drug and Alcohol Abuse
_____ Mental health/psychiatric disorders
_____ Sexually transmitted diseases

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION AND FOR VOLUNTARY INTERVIEW

(2) The purpose of this Authorization is at the request of the undersigned Patient or the undersigned personal representative of Patient.

(3) For purposes of this Authorization, I hereby request that you release to and discuss PHI with:

Butler Snow
The Pinnacle at Symphony Place
150 3rd Avenue South, #1600
Nashville, TN 37201

McCarter & English
Four Gateway Center
Newark, NJ 07102

Riker, Danzig, Scherer, Hyland & Perretti LLP
Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981
Morristown, New Jersey 07962-1981

(4) **The persons to whom PHI may be disclosed**: The information requested shall be disclosed to the person(s) identified in paragraph (3), above, or to any medical consultant or co-counsel assisting them.

(5) **No records or PHI shall be released to insurance adjusters or other persons without written authority from my attorney,_____ or me.**

(6) **Photocopy of authorization**: A photocopy of the signed original of this Authorization shall be sufficient and acceptable to all persons and entities from whom PHI is requested.

(7) **Voluntary Signature**: I understand that the signing of this Authorization is voluntary and that my treatment by a health care provider, payment for my health care or enrollment in a health plan cannot be conditioned upon my signing it.

(8) **Conflict between authorizations**: Anything in this Authorization which conflicts with another Authorization to Release Medical Records supersedes the other document(s).

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- I am authorizing the Treating Physician to use or disclose my PHI to the person(s) identified in this Authorization; and
- If I have any questions about disclosure of the PHI pursuant to this Authorization, I may contact the Treating Physician.

_____
Name of Individual, if different than patient.

_____ _____
Signature of Patient or Personal Representative — Date
Individually and as Personal Representative of the
Estate of _____, deceased.

Sworn to and subscribed before me this
_____ Day of_____ 2022

_____
Notary Public