Attachment A

Authorization to Disclose Your Protected Health Information

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

AUTHORIZED IN CONNECTION WITH

In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: _____
Patient Name: _____
DOB: _____
SSN: _____

I, _____("Individual"), authorize you ("Provider"), and your employees, agents, partners, and affiliates, to release and furnish to the agents or designees of the law firm **Jones Day**, **Kirkland & Ellis**, and/or **Litigation Management Inc. ("LMI")** copies of my protected health information as set forth below:

- All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT Scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.
- All insurance records.
- All workers' compensation claims or records, including any report of injury, all treatment records, and evidence of any benefits received/paid.

1. To the above-named person's medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition at a deposition or trial.

2. I understand that the information in the above-named person's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include

information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to the above-named person's insurance company when the law provides my insurer with the right to contest a claim under my policy. Otherwise, this authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of this health information, I can contact the releaser indicated above.

5. A notarized signature is <u>not</u> required. 45 CFR § 164.508. A copy of this authorization may be used in place of an original.

_____ _____

Signature of individual or personal representative Date

_____

Name of individual and, if applicable, personal representative

_____

Description of Personal Representative's authority to sign for individual
(attach documents that show authority)

Attachment B

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR § 164.508 TO RELEASE EMPLOYMENT INFORMATION

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name of Employer _____
Address, City, State, Zip Code _____
_____

RE: Employee Name_____ AKA_____
Date of Birth _____ Social Security Number_____
Address_____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR § 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews, and reports; transfers, statements, and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s; worker's compensation files; all medical records, x-rays, and test results; any physical examination records; all documents relating to my absences, illnesses, and injuries; any records pertaining to claims made relating to health, disability, or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file.

Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I hereby authorize and request you to release the information to the agents or designees of the law firm **Jones Day**, **Kirkland & Ellis**, and/or **Litigation Management Inc. ("LMI")** (the "Records Requester").

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 Records Requester at that time.

I acknowledge the right to revoke this authorization by sending a written revocation notice to the above-referenced address, but that this revocation notice will not apply to information already released in response to this authorization and will not affect any actions taken in reliance on this authorization prior to the date my written revocation is received. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment, or

eligibility benefits on whether I sign the authorization. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____

Signature of employee or personal representative Date

_____

Name of employee and, if applicable, personal representative

_____

Description of Personal Representative's authority to sign for employee
(attach documents that show authority)

Attachment C

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF 180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF 180 for record locations and facility addresses. Medical information may be withheld from a patient if determined that the information would be detrimental to the patient's physical or mental health or would likely cause the patient to harm himself or someone else.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next-of-kin using eVetRecs at http://www.archives.gov/veterans/military-service-records/.

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180 (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago).

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's authorized legal recipient has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's authorized legal recipient is needed in Section III of the SF 180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or authorized legal recipient. If the appropriate signature cannot be obtained, only limited types of information can be provided (DoD 6025.18-R C8). If the former member is deceased, the surviving next-of-kin (NOK) may be entitled to greater access to a deceased veteran's records than a member of the general public (DoD 6025.18-R C6.2.1.2). The NOK may be any of the following: unmarried/surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death**, **such as the DD Form 1300, Casualty Report, a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

b. Fees for records: There is no charge for most services provided to service members or next-of-kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances, service fees cannot be determined in advance. If your request involves a service fee, you will receive an invoice with your records.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 OR MORE YEARS AGO** have been transferred to the legal custody of NARA and are referred to as "archival records".

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next-of-kin is not required. In order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and may preclude the release of some information.

b. Fees for Archival Records: Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the copies of documents in the requested record, you will receive an invoice. Copies will be sent after payment is made. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number. NOTE: If requester desires to send his/her record to a third party, he/she must fill out a DD Form 2870 authorizing the releasing agency to release the record and the timeframe of the authorization. The form may be downloaded using most commercial web search tools by entering "DD Form 2870" as a search term.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health, and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (MP), 8601 Adelphi Road, College Park, MD 20740-6001. *DO NOT SEND COMPLETED FORMS TO THIS ADDRESS*. SEND COMPLETED FORMS TO THE APPROPRIATE ADDRESS LISTED ON PAGE 2 OF THE SF 180.

Authorized for lo
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2024

REQUEST PERTAINING TO MILITARY RECORDS

Requests can be submitted online using eVetRecs at http://www.archives.gov/veterans/military-service-records/

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE				☐	☐	
b. RESERVE				☐	☐	
c. NATIONAL GUARD				☐	☐	

6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN: 1. _____ 2. _____ 3. _____ 4. _____

7. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST*** *provide Date of Death if veteran is deceased:* _____

8. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation):_____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.

☐ I request inpatient/hospitalization records from _____(facility), last treated in _____(year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

2. PURPOSE: (Providing information about the purpose of the request is **voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. RELATIONSHIP TO VETERAN: _____

3. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.
☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)

☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)
☐ OTHER (Specify): _____

4. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Litigation Management Inc.("LMI")
Name

Street Address Apt. #

City State ZIP Code

Daytime Phone Fax Number

Email Address

5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

Signature Required – Do not print **Date**

* This form is available at http://www.archives.gov/veterans-military-service-records/standard-form-180.pdf on the National Archives and Records Administration (NARA) web site. *

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharged, deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	**Air Force Personnel Center** **AFPC/DP2SSM** **550 C Street West** **JBSA-Randolph TX 78150-4721** **Fax: 210-565-3124** **Email:** **DP2SSM.MILRECS.INCOMING@US.AF.MIL**	**6**	**National Archives & Records Administration Research Services (RDT1R)** **700 Pennsylvania Avenue NW Washington, DC 20408-0001**	**11**	**Department of Veterans Affairs** **ATTN: Release of Information** **Claims Intake Center** **P.O. Box 4444** **Janesville, WI 53547-4444** **Fax: 844-531-7818** **https://www.va.gov**
2	**Air Reserve Personnel Center** **Total Force Service Center: 1-800-525-0102** **https://mypers.af.mil/**	**7**	**US Army Human Resources Command's web page:** ***https://www.hrc.army.mil/content/1113*** **or 1-888-ARMYHRC (1-888-276-9472)**	**12**	**Division of Commissioned Corps Officer Support** **ATTN: Records Officer** **1101 Wooton Parkway, Plaza Level, Suite 100** **Rockville, MD 20852**
3	**Commander, Personnel Service Center (BOPS-C-MR) MS7200** **US Coast Guard** **2703 Martin Luther King Jr Ave SE** **Washington, DC 20593-7200** **https://www.dcms.uscg.mil/ompf**	**8**	**Navy Medicine Records Activity (NMRA) BUMED Detachment St. Louis** **4300 Goodfellow Boulevard, Building 103 St. Louis, MO 63120** **Fax number: 314-260-8128**	**13**	**AF STR Processing Center ATTN: Release of Information 3370** **Nacogdoches Road, Suite 116** **San Antonio, TX 78217**
4	**Headquarters U.S. Marine Corps** **Manpower Management Records & Performance (MMRP-10)** **2008 Elliot Road** **Quantico, VA 22134-5030** **SMB.MANPOWER.MMRP-10@usmc.mil**	**9**	**AMEDD Army Record Processing Center** **3370 Nacogdoches Road, Suite 116** **San Antonio, TX 78217** **Fax Number: 210-201-8310**	**14**	**National Personnel Records Center (Military Personnel Records)** **1 Archives Drive** **St. Louis, MO 63138-1002** ***http://www.archives.gov/veterans/military-service-records/***
5	**Marine Corps Forces Reserve** **2000 Opelousas Avenue** **New Orleans, LA 70114**	**10**	**Navy Personnel Command (PERS-313) 5720 Integrity Drive** **Millington, TN 38055-3130**		

Attachment D

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)

Attachment E

AUTHORIZATION FOR RELEASE OF WORKER'S COMPENSATION RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

This will authorize you to furnish copies of any and all workers' compensation records of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

Whose date of birth is _____ and whose social security number is _____.

I hereby authorize and request you to release the information to **Jones Day**, **Kirkland & Ellis**, and/or **Litigation Management Inc. ("LMI")** (the "Records Requester").

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 Records Requester at that time.

I acknowledge the right to revoke this Authorization to Release Employment Information by sending a written revocation notice to the above-referenced address, but that this revocation notice will not apply to information already released in response to this authorization and will not affect any actions taken in reliance on this authorization prior to the date my written revocation is received. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment, or eligibility benefits on whether I sign the authorization. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records herein.

This Authorization to Release Employment Information shall remain effective throughout the duration of the above-referenced litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

Attachment F-1

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

RE: Insured Name _____
Date of Birth _____ Social Security Number _____

I authorize you to furnish copies of any and all documents relating to any insurance policy or policies under which the above-referenced insured were covered and claimed benefits, including, but not limited to, claims made and payments received for such claims, as well as applications, forms, and correspondence or communications of any kind between you and the insured. I further authorize you to furnish copies of all medical, health, hospital, physicians, nursing, or allied health professional reports, records, notes, or invoices or bills in your possession related to the insured.

You are authorized to release the above records to: **Jones Day**, **Kirkland & Ellis**, and/or **Litigation Management Inc. ("LMI")** (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

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

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 Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

_____ _____
Signature of witness Date

Attachment F-2

AUTHORIZATION FOR RELEASE OF CROP INSURANCE RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

Requester: _____
(Grower's Name)

Requester's Current Address: _____

_____

Date of Birth: _____

Social Security Number: _____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine of not more than $10,000.00 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552(a)(i)(3) by a fine of not more than $5,000.00.

I request that the following records be released:

> Full and complete copies of all insurance policies, claims submitted, and any maps, plat books and descriptions of land or property related to any insurance coverage provided to [Farmer Name] and/or [Farming Entity Name], individually, jointly and/or by and through one or more partnerships, corporations or other entities, by the United States Department of Agriculture, Farm and Foreign Agriculture Services, Farm Service Agency, the Risk Management Agency and/or any private entity, from January 1, 1964 through the present, inclusive.

Pursuant to 7 U.S.C. § 1502(c)(2)(B), I further request, authorize and direct you to release any and all information relating to [Farmer Name] and/or [Farming Entity Name], including the foregoing records, to **Jones Day**, **Kirkland & Ellis**, and/or **Litigation Management Inc. ("LMI")**.

I am voluntarily signing this consent, without promises being made to me, or any entity that I represent, nor under threat of duress or coercion.

NAME: _____

SIGNATURE: _____ (Signature of Grower/Requester)

DATE AND TIME: ______________________________________

Attachment G

AUTHORIZATION FOR RELEASE OF DISABILITY CLAIMS RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

RE: Claimant Name_____
Date of Birth _____ Social Security Number_____

I authorize you to furnish copies of any and all records of disability claims of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning the above-referenced claimant.

You are authorized to release the above records to: **Jones Day**, **Kirkland & Ellis**, and/or **Litigation Management Inc. ("LMI")** (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

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

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 Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

_____ _____
Signature of witness Date

Attachment H

AUTHORIZATION FOR RELEASE OF FSA DOCUMENTS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

RE: Requester: _____
Doing Business As (Grower's Name): _____
Requester's Current Address: _____
Date of Birth _____ Social Security Number_____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine of not more than $10,000.00 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552a(i)(3) by a fine of not more than $5,000.00.

A. *Record Release:* I request that the following records be released:

1. All FSA records (including FSA 578, 1026A (if applicable), the USDA FSA Detailed Acreage History Report Form and aerial maps) and all records from the Risk Management Agency of the USDA relating to the above-named requester or any entity by or through which he or she may farm for the years **1964 through the present**.

Pursuant to 5 U.S.C. § 552a(b), I further request, authorize the release of any and all information relating to me, including the foregoing records, to: **Jones Day**, **Kirkland & Ellis**, and/or **Litigation Management Inc. ("LMI")** (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

I am voluntarily signing this consent, without promises being made to me, or any entity that I represent, nor under threat of duress or coercion.

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 Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

[Signature Page to Follow]

Signature of Grower/Requester | Date

Name of Grower/Requester

Description of Requester's authority to sign for Grower
(attach documents that show authority)

Signature of witness | Date