SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

IN RE LAOSD ASBESTOS LITIGATION	JCCP Case No. 4674 **ORDER REGARDING PLAINTIFFS' AUTHORIZATIONS** Dept: 324 Judge: Hon. Emilie H. Elias

All JCCP 4674 cases are deemed to be complex litigation within the meaning of the California Standards of Judicial Administration for Complex Litigation Section 19 and California Rules of Court, rule 3.400 et. seq. As such, JCCP 4674 cases require specialized management to avoid placing unnecessary burdens on the Court or the litigants, and to keep costs reasonable. The Court finds that the entry of this Order will benefit the Court, counsel and litigants, and will further the orderly conduct and management of asbestos litigation (JCCP 4674) in this jurisdiction. This effective date of this Order in asbestos litigation (JCCP 4674) shall be February 1, 2012. In complying with this Order, Plaintiffs do not waive any work-product protections or attorney client privileges or any other privilege, protection or objection under the law.

I. SELECTION AND RESPONSIBILITIES OF VENDOR

A. Defendants have designated and the Court has approved Pike Photocopy, Inc., located at 4221 Sepulveda Blvd., Culver City, CA 90230-4708 (hereinafter "VENDOR") as the defense copy service for the production of Plaintiffs' executed AUTHORIZATIONS and records.

B. VENDOR agrees to be bound by all the laws of the State of California and the United States, including but not limited to laws and regulations under H.I.P.P.A.

C. If any party has any issues with the VENDOR, they shall make good faith efforts to resolve the issues with the VENDOR. If, after good faith efforts, issues with the VENDOR still remain and cannot be resolved, the party may file a noticed motion in JCCP 4674 to bring the issues regarding the VENDOR to the Court's attention. The motion shall be filed in JCCP 4674 number, with notice to be provided to all counsel in JCCP 4674, and shall be accompanied by a declaration identifying the issues, detailing the good faith efforts that have been made to resolve them, and stating what issues still remain.

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II. AUTHORIZATIONS

A. Within 14 days after filing an original complaint in personal injury actions or 30 days after filing an original complaint in wrongful death actions, Plaintiffs shall provide to VENDOR, at the address indicated in Section I.A above, the following items:

1. Copies of Plaintiffs' complaint, exhibits to the complaint (if any).

2. Original AUTHORIZATIONS (no facsimile copies) as follows:

   a. In every case: Social Security records; Medicare and Medicaid records; military and Veteran Affairs records; medical records, including billing, radiology and pathology records; union records and employment records, using the forms attached hereto as **Exhibit A**. The AUTHORIZATIONS are to be signed by Plaintiff in personal injury actions, or by the lead Plaintiff or the estate's representative in wrongful death actions, and;

   b. As applicable in each case: AUTHORIZATION(S) attached hereto as **Exhibit B,** which are to be signed by Plaintiff in personal injury actions, or by the lead Plaintiff or the estate's representative in wrongful death actions.

   c. The AUTHORIZATIONS shall have the information relating to Plaintiff or decedent filled out, including Plaintiff's or decedent's name, residence, date of birth, and Social Security number.

3. A list of the names, and addresses and phone numbers as known, of all medical facilities and treating physicians, employers, and unions which are known to Plaintiffs, based on exercise of due diligence, at the time of the submission of the AUTHORIZATIONS to VENDOR.

B. If additional facilities and treating physicians, employers and unions not previously disclosed in Section II.A.3 are discovered **within** 30 days after the submission of the initial list to VENDOR, Plaintiffs shall promptly provide to

VENDOR a supplemental list with the names, addresses and phone numbers of the subsequently discovered entities.

C. If additional facilities and treating physicians, employers and unions not previously disclosed in Section II.A.3 are discovered **after** 30 days of the submission of the initial list to VENDOR, at VENDOR's request, Plaintiffs shall promptly provide to VENDOR a supplemental list with the names, addresses and phone numbers of the subsequently discovered entities.

D. When any item in Sections II.A-C, is provided to VENDOR, a Proof of Service shall be included.

E. Within 7 days of a written request by VENDOR, Plaintiff shall provide the original signed copies (no facsimile copies) of any additional or follow up AUTHORIZATIONS that may be needed to acquire records, with all of the relevant information filled in, to the VENDOR along with a Proof of Service. Additional or follow up AUTHORIZATIONS are not meant to include any authorizations that an individual Defendant may prefer to use for the same categories of records already covered by the AUTHORIZATIONS in Exhibit A. It is meant to address those situations where a particular facility or entity would require a specific form that is different from the AUTHORIZATIONS in Exhibit A.

F. Should it be determined that notarization or any additional information is needed to obtain records, parties shall meet and confer in good faith to resolve any issues relating to the notarization or the additional information needed, including issues pertaining to costs.

G. AUTHORIZATIONS shall be valid for 2 years from the date of signature.

H. VENDOR shall have no contact with individual Plaintiffs themselves directly or indirectly, but will communicate only with counsel for Plaintiffs and Defendants.

I. Plaintiffs shall post the Proofs of Service, as provided in Section II.D, and the lists of facilities and entities, as provided in Section II.A-C, related documents on

LexisNexis by the business day following the service of the AUTHORIZATIONS and/or lists on VENDOR.

J. Within 5 calendar days of the receipt of signed AUTHORIZATIONS, VENDOR shall provide acknowledgment of receipt to all parties.

III. RECORDS RETRIEVAL

A. Upon receipt of the list of relevant facilities and the signed, original AUTHORIZATIONS, VENDOR shall promptly contact all Defendants in the case and notify them of the identified facilities and availability of AUTHORIZATIONS.

B. Upon request by one or more Defendants to VENDOR for documents from any of the facilities, VENDOR shall immediately commence procedures to obtain said documents.

C. The method for sharing the costs of obtaining these records shall be the subject of agreements between Defendants and VENDOR.

IV. PLAINTIFFS' FIRST LOOK

A. Within 5 calendar days of receipt of records from a facility, VENDOR shall provide bates-numbered electronic, read-only copies of the records to Plaintiffs' attorneys.

B. Should Plaintiffs want hard copies or a printable electronic version of the documents retrieved by VENDOR, Plaintiffs shall order records from VENDOR at a cost to be arranged between Plaintiffs and VENDOR.

C. VENDOR shall not discuss the contents of said records with Defendants, nor disclose the contents, nor produce any of said records to Defendants in any case without giving Plaintiffs an opportunity first to review for production.

D. Plaintiffs shall have 7 calendar days in personal injury cases and 21 days in wrongful death cases from the day that the records are received from VENDOR, in which to review the records. Upon review, should Plaintiffs determine in good faith that any part of the records are not subject to disclosure and/or are privileged

based upon any privacy objections or then existing privilege under California law, Plaintiffs shall serve a **Notice of Redacted Records** to all parties via LexisNexis and to VENDOR, via facsimile, within 7 days or 21 days as provided above. The Notice of Redacted Records shall identify each document that is being redacted and state the basis for the objection to disclosure, the Bates numbers(s) and author(s), date and title of the subject document if applicable. Plaintiffs shall simultaneously serve the Notice of Redacted Records on all parties.

E. At the expiration of the 7 day or 21 day First Look period, as provided for in Section IV.D above, VENDOR shall make available all records that are not identified in a Notice of Redacted Records to Defendants.

F. If Plaintiff(s) serve(s) a Notice of Redacted Records and a Defendant wishes to obtain the subject records, that Defendant shall contact Plaintiffs to meet and confer, and parties shall meet and confer in good faith, to resolve the related issues. If parties are unable to resolve the issues and Defendant still wishes to obtain the subject records, Defendant shall serve Plaintiffs with a statement explaining its position why it should be allowed to obtain the records. Within 10 days in a preference case (or 30 days in a non-preference case) from the date of service of Defendant's statement, Plaintiffs shall: (1) serve Defendants with a statement explaining why Defendants should not be allowed to obtain the subject records; and (2) file and serve a joint statement containing both Plaintiffs' statement and Defendant's statement. The redacted records shall not be filed, but it shall be lodged with the court, along with the joint statement, for *in camera* review as to the basis for the objection.

G. In the event the Court orders redacted documents produced, VENDOR shall make available to Defendants the items pursuant to the terms of the court order.

V. OTHER PROVISIONS

A. Upon receiving written notification from Plaintiffs that a particular litigation matter identified by case name and case number has been fully and finally

dismissed as to all parties, VENDOR shall destroy all records and AUTHORIZATIONS relating to that case number within one (1) month of the notification. VENDOR shall provide to attorneys for Plaintiffs a statement made under penalty of perjury that this destruction has been completed in a confidential manner to protect Plaintiffs' privacy rights.

B. Nothing in this Order should be construed or used as a separate means for excluding evidence at trial. Nothing in this Order shall relieve Plaintiffs from complying with the discovery obligations under the applicable statutes, General Orders, or case law.

IT IS SO ORDERED.

Dated: January 31, 2012

Emilie H. Elias
Judge of the Los Angeles Superior Court

EXHIBIT A

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO
45 FR 164-508

Name of the person(s), or class of persons, authorized to make the requested disclosure:

_____

_____

_____

_____

_____

Patient name:_____
aka:_____
Date of birth:_____ Social Security #:_____
Address:_____

I authorize the disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to _____.

Including the following:
-All medical records, including in-patient, out-patient 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.
-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.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows (check all that apply):

___Yes, disclose HIV/AIDS information OR
___ No, do not disclose HIV/AIDS information.
___Yes, disclose alcohol/substance abuse information OR
___ No, do not disclose alcohol/substance abuse information

I authorize you to release the protected health information to:
Pike Photocopy, Inc., 4221 Sepulveda Bl., Culver City, CA 90230,
(310) 397-0400, Fax: (310) 398-6309.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records. I have a right to receive a copy of this authorization. I acknowledge the right to revoke this authorization by writing to the handling attorney or paralegal. However, I understand that any actions already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45CFR 164.508. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization expires two years from the date below.

Signature: _____ Date: _____
Relationship to the person who is the subject of the records:
Self:_____ Other (describe authority):_____
_____

UNION RECORD AUTHORIZATION

TO: _____
_____
_____
_____

RE: _____

This Authorization is to authorize you to give Pike Photocopy, Inc., 4221 Sepulveda Blvd., Culver City, CA 90230; Tel: (310) 397-0400, Fax: (310) 387-6309.

All papers, documents, notes, memoranda, correspondence, employment reports; evaluations, application forms, employment histories and records of every description pertaining to any and all aspects of the application, employment and termination of the undersigned.

For their examination, retention, review and photocopying.

The above information is material and relevant to the above referenced lawsuit. Said information may be disclosed by attorneys to any other attorneys in said action and is to be used in the preparation of litigation and in litigation.

This authorization shall remain valid for two (2) years from the date of the signing hereof.

The undersigned acknowledges that he has the right to receive a copy of this authorization.

DATED: _____ _____
UNION MEMBER

_____
MEMBER'S SOCIAL SECURITY NUMBER

EMPLOYMENT RECORD RELEASE AUTHORIZATION

TO: _____

_____

_____

RE: _____

I AUTHORIZE any employer, business, accountant, bookkeeper or other entity or person to release records of any kind, including but not limited to, employment, personnel, reports, documents, correspondence, notes, ledgers, journals, applications for employment, medical and health records, information regarding raises, promotions, absenteeism, disciplinary actions, evaluations, terminations, and any other records from the first date of employment to the present date regarding the above-named employee.

I AUTHORIZE you to give Pike Photocopy, Inc., 4221 Sepulveda Blvd., Culver City, CA 90230; Tel: (310) 397-0400, Fax: (310) 398-6309, any and all such information.

I UNDERSTAND that the information obtained by use of the Authorization will be used by the aforementioned law firm and other persons and organizations performing business or legal services in connection with the pending claim and/or litigation concerning me, or as may be otherwise lawfully required or as I am otherwise authorize.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for two years from the date shown below as that of my signature, unless revoking IN WRITING.

I CERTIFY that I have read and understand the foregoing; that I agree and consent to the release of information and records as set forth above; that my consent and authorization is freely given; that I have received a copy of this authorization; and I acknowledge that I have the right to receive a copy of this signed authorization pursuant to the provisions of California Civil Code Section 56.10.

DATED: _____ _____

Signature of Employee or Legal Representative

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name | *Date of Birth | *Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
Pike Photocopy, Inc.	4221 Sepulveda Blvd., Culver City, CA 90230
(310) 397-4000, Fax: (310) 398-6309	

*I want this information released because: Asbestos Litigation Discovery
There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- [ ] Social Security Number
- [X] Current monthly Social Security benefit amount
- [X] ~~Current monthly Supplemental Security Income payment amount~~
- [X] My benefit/payment amounts from _____ to _____
- [X] My Medicare entitlement from _____ to _____
- [ ] Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- [X] Complete medical records from my claims folder(s)
- [X] Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) Applications, questionnaires, consultative exams, evaluations, determinations, retirment folder, disability benefits.

I am the individual to whom the requested information/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 in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, 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 any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(If not the individual)*: _____ *Daytime Phone: _____

Form SSA-3288 (07-2010) EF (07-2010)

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, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any 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 "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- 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 information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, 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. The information you provide will be used to respond to your request for SSA records information or process your request when we 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, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided 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. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at 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 (TTY 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.*

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____ Social Security Number _____

Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

☒ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

Asbestos Litigation Discovery

☐ **Certified Yearly Totals of Earnings (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Social Security Statement)** For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ _____

Do you want us to certify the information? ☒ Yes ☐ No

If yes, enter $15.00 . . . . . B. $ 15.00

ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ _____

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____

Daytime Phone Number _____ _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name Pike Photocopy, Inc. Address 4221 Sepulveda Blvd.,

City, State & Zip Code Culver City,CA 90230 (310) 397-4000, Fax: (310) 398-6309

6. Mail Completed Form(s) To:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore, Maryland 21290-3003

Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore, Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings

Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Social Security Statement

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

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 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

INFORMATION ABOUT YOUR REQUEST

- **How Do I Get This Information?**

  You need to complete the attached form to tell us what information you want.

- **Can I Get This Information For Someone Else?**

  Yes, if you have their written permission. For more information, see page 3.

- **Who Can Sign On Behalf Of The Individual?**

  The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

- **Is There A Fee For This Information?**

  1. Certified/Non-Certified Detailed Earnings Information

  Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

  Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

  Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

  We will certify the detailed earnings information for an additional fee of $15.00. Certification is usually not necessary unless you plan to use the information in court.

  2. Certified Yearly Totals of Earnings

  Yes, there is a fee of $15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.

  3. Method of Payment

  Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.

2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	$15.00	15	$ 43.75	28	$ 64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

- **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

Standard Form 180 (Rev. 10/10) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10-31-2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

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

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	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 COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☒ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy.** When was the DD Form(s) 214 issued? YEAR(S):

☒ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: 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.

☒ **All Documents in Official Military Personnel File (OMPF)**

☒ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, the facility name and date for each admission must be provided:

☐ **Other** (Specify):

2. **PURPOSE:** (An explanation of the purpose of the request is **strictly voluntary**; however, such information 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.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal

☒ Other, explain: **Asbestos Litigation Discovery**

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER IS:** *(Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran **(Must provide proof of death).**
Show relationship: _____
(See item 2a on accompanying instructions)
☐ Legal guardian (Must submit copy of court appointment)
☐ Other (specify) _____

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

Pike Photocopy, Inc. Tel: (310) 397-0400
Name 4221 Sepulveda Bl. Fax: (310) 398-6309
Street Apt.
Culver City, CA 90230
City State Zip Code

3. **AUTHORIZATION SIGNATURE REQUIRED** *(See items 2a or 3a on accompanying instructions.)* 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 III is true and correct.

_____
Signature Required - Do not print
Date of this request ( ) Daytime phone
Email address

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

LOCATION OF MILITARY RECORDS

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	ADDRESS CODE	
		Personnel Record	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 on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay 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	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	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 on or after 1/1/1999	4	11
	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	14
	Discharged, deceased, or retired after 10/16/1992	14	11
	Active enlisted, officers (including National Guard and Army Reserve on active duty in the U.S. Army)	7	
	National Guard enlisted and officers not on active duty in Army	13	
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 on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service • Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	Air Force Personnel Center HQ AFPC/DPSSRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center/DSMR HQ ARPC/DPSSA/B 6760 E. Irvington Place, Suite 4600 Denver, CO 80280-4600	7	U.S. Army Human Resources Command www.hrc.army.mil	12	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852
3	Commander, CGPC-adm-3 USCG Personnel Command 4200 Wilson Blvd., Suite 1100 Arlington, VA 22203-1804	8	*Reserved.*	13	The Adjutant General (of the appropriate state, DC, or Puerto Rico)
4	Headquarters U.S. Marine Corps Personnel Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030	9	*Reserved.*	14	National Personnel Records Center (Military Personnel Records) 9700 Page Ave. St. Louis, MO 63132-5100 eVetRecs! www.archives.gov/veterans/evetrecs/
5	Marine Forces Reserve 4400 Dauphine St. New Orleans, LA 70146-5400	10	Navy Personnel Command (PERS-312E) 5720 Integrity Drive Millington, TN 38055-3120		

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

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) 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. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

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/evetrecs/.

2. Personnel records and Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **less than 62 years** ago and STR's 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). STR's of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs approximately 40 days after the last day of active duty. (See item 3, Archival Records, if the military member was discharged, retired or died in service over 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 and 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 legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel records and/or STR's must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **must provide proof of death**, such as a copy of a death certificate, letter from funeral home or obituary.

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 be notified as soon as that determination is made.

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. However, 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 preclude the release of some information.

b. Fees for Archival Records: Access to archival records is granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). You will be notified if there is a charge for photocopies of documents contained in the record you are requesting.

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.

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 (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA ns permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send this form or requests for benefits to this address.**

TO	Department of Veterans Affairs	NAME OF INDIVIDUAL *(Type or print)*	
		VA FILE NO. *(Include prefix)*	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Pike Photocopy, Inc. (310) 397-0400, Fax: (310) 398-6309
4221 Sepulveda Bl., Culver City, CA 90230

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶	NAME

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each)*

All documents, all medical records, all applications (including offline applications and online applications via VONAPP), all proofs of claim, and all statements in support of claim, including but not limited to VA Forms 21-526, 21-534, 21-535, 21-4138, 21-4176, 21-8940 and 29-357, submitted in support of any claim for disability compensation benefits.

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

Asbestos Litigation Discovery.

NOTE: Additional information may be listed on the reverse side of this form.

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)*	DATE

VA FORM OCT 1995(R) **3288**

AdobeFormsDesignor

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Pike Photocopy, Inc. , (310) 397-4000, Fax: (310) 398-6309
4221 Sepulveda Blvd., Culver City, CA 90230

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM MAY 2005 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

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 <u>one</u> 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 <u>only</u> 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 <u>one</u> box 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:** Pike Photocopy, Inc.

   Address: 4221 Sepulveda Blvd.

   Culver City, CA 90230 (310) 397-4000, (310) 398-6309

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 no longer 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 only applies 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:**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90-Seventh Street Ste 5-300
San Francisco, CA 94103-6706
415-744-3658/Fax: 744-2706

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.

EXHIBIT B

Employment Development Department
State of California

AUTHORIZATION FOR RELEASE OF RECORDS

Instructions: This form must be completely filled out and mailed to the address below:

Employment Development Department
P.O. Box 826880, MIC 53
Sacramento, CA 94280-0001

I, _____, authorize the
Type or Print Name

Employment Development Department to release a copy of my records pertaining to:
Disability insurance records, questionnaires, evaluations, determinations; consultation examination reports, unemployment insurance records.
Specify Type of Record – Example: Unemployment Insurance Records, Disability Insurance Records

for the period of _____ through _____ to the
MM/DD/YY MM/DD/YY

following individual or entity (or its representative):

Pike Photocopy, Inc., (310) 397-4000, Fax: (310) 398-6309
Name of Individual/Entity (or its Representative)

4221 Sepulveda Blvd.
Address

Culver City, CA 90230
City, State, Zip Code

This Authorization shall remain in effect for 90 days from date of signature or as otherwise specified. A copy of this Authorization shall be as valid as the original.

Date: _____ _____
MM/DD/YY Signature

_____
Social Security Number*

* Providing your social security number on this form is voluntary and if you provide your social security number, it will be used solely for the purpose of locating the requested records. If you choose not to provide your social security number, the Employment Development Department may be unable to locate any or all requested records due to the Employment Development Department's use of social security numbers for record identification and filing purposes.
Privacy Act of 1974 Section 7(b) (Public Law 93-579).

DE 5500 (3-10) CU

COUNTY OF LOS ANGELES • REGISTRAR-RECORDER/COUNTY CLERK, P.O. BOX 489, NORWALK, CA 90651-0489 (562) 462-2137

APPLICATION FOR DEATH RECORD

Pursuant to Health and Safety Code 103526, the following individuals are entitled to an AUTHORIZED Certified Copy of a death record.

- A member of a law enforcement agency or a representative of another governmental agency, as provided by law, who is conducting official business.
- A child, grandparent, grandchild, sibling, spouse or domestic partner of the registrant
- An attorney representing the registrant or the registrant's estate, or any person or agency empowered by statute or appointed by a court to act on behalf of the registrant or the registrant's estate.
- Any funeral director or agent/employee of a funeral establishment acting within the scope of their employment who orders certified copies of a death certificate on behalf of any individual specified in paragraphs (1) to (5), inclusive of subdivision (a) of Section 7100 of the Health and Safety Code.

If applying in person the application must be signed in the presence of the cashier.
Those who are not authorized may receive an INFORMATIONAL Certified Copy with the words "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY" imprinted across the face of the copy.

MAIL REQUESTS FOR AUTHORIZED COPIES MUST BE ACCOMPANIED BY A NOTARIZED CERTIFICATE OF IDENTITY

☐ I am requesting an AUTHORIZED copy ☐ I am requesting an INFORMATIONAL copy

	NUMBER OF COPIES NUMERO DE COPIAS		
	Month/Mes	Day/Dia	Year/Año
Date of Death - Fecha De Defuncion			

NAME OF DECEASED (first, middle , last) - NOMBRE DEL DIFUNTO (primero, segundo, apellido)

CITY OF DEATH - CIUDAD DE DEFUNCION

RELATIONSHIP TO REGISTRANT (SEE ABOVE) - PARENTESCO CON LAS PERSONA REGISTRADA (VEÁSE ARRIBA)

I _____ certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date _____ Signature_____

FOR RECORDER USE ONLY

File Number Searched _____

Doubled _____

Veterans-See reverse side of first copy
Veteranos-Vean el dorso de la segunda copia

DL/ID_____

NAME/NOMBRE

STREET ADDRESS/NUMERO Y CALLE

CITY :CIUDAD STATE/ESTADO ZIP/ZONA POSTAL

76A639D Rev. 5/10