IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

IN RE: LIPITOR (ATORVASTATIN CALCIUM) MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	)	**MDL No. 2502**
	)	**MDL No. 2:14-mn-02502-RMG**
This Fact Sheet Relates To:	)	
MDL Case No._____	)	**Plaintiff: _____**

PLAINTIFF FACT SHEET*

A. CASE INFORMATION - Please state the following for the civil action you filed:

1. Case caption and number:_____
2. Principal attorney name: _____
3. Firm: _____
4. Telephone number: _____Fax number: _____
5. E-mail address: _____
6. If this fact sheet is being completed in a representative capacity (e.g., on behalf of the estate of a deceased person), provide the representative's name, relation to deceased, and the capacity in which he/she is representing Plaintiff: _____

_____

B. PERSONAL INFORMATION FOR PLAINTIFF

1. Plaintiff's current full name:_____
   First Middle Last

   Plaintiff's other names, including maiden names, nicknames, and aliases, Plaintiff has used or by which she has been known, and the date(s) of use:

   _____
   First Middle Last Date(s)

   _____
   First Middle Last Date(s)
2. Plaintiff's social security number (including any previous SSNs if applicable):
   _____
3. Plaintiff's date and place of birth:
   _____

* Please see Exhibit A for instructions and definitions for completing this document.

4. Plaintiff's date and cause of death, if applicable:

   _____

5. Plaintiff's highest level of education:_____

6. Current spouse's full name:_____
   First Middle Last

7. Is Plaintiff's spouse making a loss of consortium claim in this action? Yes☐ No☐

8. **Residence(s).** Identify each residence where Plaintiff has lived from ten (10) years prior to diabetes diagnosis until the present.

Address	Dates of residence

9. **Lawsuits and Criminal History.** If Plaintiff has ever been a party to an arbitration or civil lawsuit, other than this action, including any Worker's Compensation, Social Security, bankruptcy, or other administrative proceedings, or ever been convicted of or pled guilty to a felony or crime other than a minor traffic violation, provide the following:

Case Name, Court, Caption & Case Number	Date filed	Nature of case & resolution

10. **Employment History**. Provide the following information for Plaintiff's employment, including self-employment and military service from ten (10) years prior to diabetes diagnosis until the present. If the Plaintiff is making a claim for lost wages in this case, also list, for each position, her salary and/or other compensation received.

Employer's Name, Supervisor, Address, Telephone Number	Dates of Employment	Occupation/ Job Title	Reason for Leaving	Description of Job Duties	Salary/Annual Gross Income

Employer's Name, Supervisor, Address, Telephone Number	Dates of Employment	Occupation/ Job Title	Reason for Leaving	Description of Job Duties	Salary/Annual Gross Income

C. FAMILY INFORMATION

To the extent known, provide the following information about (1) every parent, grandparent, child, grandchild, sibling, aunt, or uncle of Plaintiff who has ever been diagnosed with diabetes, and (2) any parent, grandparent, child, grandchild, or sibling of Plaintiff who has ever been diagnosed with cardiovascular disease, atherosclerosis, hypertension, or other risk factors for heart disease, as well as those who suffered a heart attack or stroke:

Relationship to Plaintiff	Diabetes and/or Heart-Related Medical History	Date of Diagnosis	If deceased, age at and cause of death

D. ALLEGED INJURIES AND DAMAGES

1. For each injury you believe Plaintiff sustained as a result of ingesting Lipitor or atorvastatin, provide the following information and attach all medical records related to the alleged injuries:

Injury Alleged	Date First Aware of Injury	Permanent?	Healthcare Provider Who Diagnosed	Date of Diagnosis

2. Provide the following information about each treatment undertaken or scheduled to treat any of the injuries alleged in D.1 and attach all medical records related to each treatment:

Treatment Recommended or Initiated	Date Ordered or Initiated	Ordering/Treating Physician and Address

E. HEALTH AND MEDICAL HISTORY OF PLAINTIFF

1. **Background Information**:

a. Plaintiff's height: _____

b. Plaintiff's weight at first ingestion of Lipitor/atorvastatin calcium: _____

c. Plaintiff's weight at diagnosis of type II Diabetes: _____

d. Plaintiff's current weight: _____

e. Plaintiff's highest adult weight and date(s) of occurrence (excluding pregnancy): _____

f. Has Plaintiff given birth to a baby over nine (9) pounds? Yes☐ No☐

g. Date on which Plaintiff was diagnosed with type II diabetes:
_____

h. Healthcare provider who diagnosed Plaintiff with type II diabetes:
_____

i. Is Plaintiff currently taking a statin? Yes☐ No☐

If yes, which one, who prescribed and why? _____

If no, what was the last statin taken and when and why did Plaintiff stop taking it?
_____

2. **Statin Prescriptions.** Provide the following for each statin used and each Healthcare Provider who ever prescribed (or provided samples of) any statin to Plaintiff:

Statin Used	Start and End Dates	Dosage and Frequency (per day)	Prescribing Healthcare Provider and Address	Why Statin Was Prescribed	Dispensing Pharmacy or Source of Sample	Manufacturer, Seller, Distributor or Drug Co., and NDC No.

3. **Disability History**. If Plaintiff has sought, filed for, or received any disability benefits, including but not limited to: medical or hospital insurance policy benefits, Workers Compensation benefits, sickness, accident or disability benefits provided by or through an employer for non-employment-related conditions, Social Security disability benefits, Veterans' medical/disability benefits, or union disability benefits, please complete below:

Date Applied and Dates Out of Work	Health Conditions at Issue	Employer

4. **Medical Conditions**: Provide the following information about Plaintiff's experience, if any, with the medical conditions below:

Medical Conditions	Experienced? (Y/N)	Date Plaintiff First Learned She Had This Condition	Treating Healthcare Provider(s)	Course and Nature of Treatment(s)
Elevated blood glucose				
Elevated fasting triglycerides				
Overweight or Obesity				
Body mass index ≥25				
Hypertension				
Metabolic Syndrome				
Polycystic ovary syndrome				
Gestational diabetes				
Cardiovascular disease				
Peripheral neuropathy				
Retinopathy and blindness				

Medical Conditions	Experienced? (Y/N)	Date Plaintiff First Learned She Had This Condition	Treating Healthcare Provider(s)	Course and Nature of Treatment(s)
Kidney disease				
Prolonged wound healing				
Amputation				
Stroke				
Heart attack				
Angina				
Revascularization Procedure				
Heart failure				
Heart disease				
Coronary artery disease				
Hyperglycemia / High Blood Glucose				
Pre-diabetes				

5. **Other Medical History.** Provide the following information about any injury, illness, medical condition, or disability not otherwise identified above, other than the common cold or flu, that Plaintiff has experienced in the last twenty (20) years:

Injury or Condition	Approximate Date of Onset

6. **Discussions with Prescriber or Pharmacist**. During Plaintiff's visit(s) to the prescribing doctor or pharmacist, was she provided any written information about Lipitor/atorvastatin calcium by the doctor, pharmacist, or his or her staff?

Yes: ☐ No: ☐ Do Not Recall: ☐

If you answered yes, please (a) provide copies of any such information Plaintiff received, or (b) describe the information received:

_____

_____

7. **Healthcare Providers**. Provide the following information about each Healthcare Provider with whom Plaintiff consulted or treated within the last twenty (20) years:

Name of Healthcare Provider, Facility, and Address	Specialty	Illness, Injury or Condition for which care was sought?	Diagnosis and Treatment Recommended	Dates of Care or Treatment

8. **Pharmacies.** Provide the following information about all pharmacies at which Plaintiff filled prescriptions for medications, specifically including but not limited to those pharmacies at which Plaintiff filled prescriptions for Lipitor or atorvastatin calcium for the last twenty (20) years, as well as pharmacies at which Plaintiff filled prescriptions for statins at any time. This includes all drug stores, supermarkets, hospital pharmacies, online pharmacies, mail-order pharmacies, or any other location or service.

Name of Pharmacy	Address of Pharmacy	Approximate Dates Used	Lipitor or atorvastatin supplied?

Name of Pharmacy	Address of Pharmacy	Approximate Dates Used	Lipitor or atorvastatin supplied?

9. **Prescription and Non-Prescription History**. Provide the following information about all prescription and non-prescription medications, including vitamins, herbal preparations, dietary supplements, and prenatal vitamins ("Medications") that Plaintiff has taken for the last twenty (20) years to the extent not already provided in medical and pharmacy records that you are providing as attachments to this completed Plaintiff Fact Sheet:

Medication Used	Start and End Dates	Dosage and Frequency (per day)	Prescribing Healthcare Provider (if any)	Why Medication Was Taken or Prescribed	Dispensing Pharmacy, Drug Store, or Retail Outlet

10. **Alcohol Use**. Check one box for each question below:

a. During the five (5) years prior to her type 2 diabetes diagnosis, Plaintiff used alcohol: ☐ None ☐ < 1 drink/week ☐ 1-5 drinks/week ☐ 6-10 drinks/week ☐ > 10 drinks/week

b. During the one (1) year prior to her type 2 diabetes diagnosis, Plaintiff used alcohol: ☐ None ☐ < 1 drink/week ☐ 1-5 drinks/week ☐ 6-10 drinks/week ☐ > 10 drinks/week

11. **Tobacco Use**. Provide the following about Plaintiff's history of tobacco use:

Type of Tobacco Used	Timeframe of Use	Frequency of Use	Amount of Tobacco Used

12. **Exercise and Physical Activity**.

Provide the following information about physical activity, including any specific exercise(s), sports, and vocational or recreational activities, that Plaintiff has engaged in from ten (10) years prior to diabetes diagnosis until the present:

Activity	Frequency (days per week)	Intensity (High, Moderate, Low)	Duration (Time)	Dates/Time Period

13. **Diet and Nutrition**. Provide the following information about Plaintiff's diet from ten (10) years prior to diabetes diagnosis until the present, including identifying any diet or nutritional program that Plaintiff engaged in or that has been prescribed or recommended to her by any Healthcare Provider.

Name of Diet or Nutritional Program	Description of the Program	Purpose	Outcome	Timeframe of Adherence	Frequency of Adherence

14. **Communications with Pfizer**. Provide the following information about any communication between Plaintiff or anyone acting on her behalf with any employee, agent, or representative of Pfizer (excluding communications between counsel for the parties since the filing of this lawsuit):

Person(s) Involved In Communication	Date(s)	Form and Location of Communication	Substance of Conversation	Circumstances of Communication

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information, and belief, and that I have supplied all the documents requested in this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

Further, by signing below, I waive notice under the Federal Rules of Civil Procedure, or other applicable law or rule, of subpoenas or other requests for production of medical records directed to Healthcare Providers identified in this Plaintiff Fact Sheet.

_____ _____

Plaintiff's Name (Signature) Date

_____

Plaintiff's Name (Printed)

_____

Representative's Name (where applicable) (Signature)

_____

Representative's Name (Printed)

EXHIBIT A

INSTRUCTIONS

1. Each Plaintiff alleging she developed diabetes or any person who filed on behalf of or as the administrator of the estate of any such person must complete this separate form. If you are completing this document in a representative capacity, such as on behalf of a deceased Plaintiff, please answer the questions provided herein on behalf of the Plaintiff or deceased you represent.

2. All the responses in this Fact Sheet or an amendment thereto are binding upon Plaintiffs as if they were contained in answers to interrogatories.

3. In completing this Fact Sheet, you are under oath and must provide information that is true and correct. You must answer every question as specifically as possible. **If you cannot recall all of the details requested, please provide as much information as you can.** For example, if a question asks for a date and the exact date is not known or capable of being ascertained, an approximate date should be provided (e.g., "approximately mid-2001"). You may and should consult records in your possession that contain responsive information to assist you in responding. You may be requested to provide copies of such documentation that are in your possession.

4. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. Each question in this Fact Sheet is continuing in nature and requires supplemental answers if you obtain further information between the time of answering and the trial.

5. Each question in this Fact Sheet should be construed independently, unless otherwise noted. No question should be construed by reference to any other question if the result is a limitation of the scope of the answer to such question.

6. The questions herein do not seek the discovery of information protected by the attorney-client privilege.

7. Your lawyer has an electronic version of this Fact Sheet that can expand to accommodate as much information as is necessary to fully answer any of these questions. If you are filling out a paper copy of this Fact Sheet, you may photocopy and submit as many copies of any page of this Fact Sheet as is necessary to fully answer any question. **Attach additional pages as necessary to fully answer each and every question.**

DEFINITIONS

Plaintiff or "You": The person whose ingestion of Lipitor or atorvastatin calcium allegedly caused her to develop diabetes.

Healthcare Provider: Any provider of healthcare, including, without limitation, surgeons, physicians (whether M.D.s, homeopaths, osteopaths, or chiropractics), physician assistants, physical, occupational, or rehabilitative therapists, nurses, nurse practitioners, psychologists,

dentists, psychiatrists, social workers, alternative health care practitioners, counselors, or other practitioners of the healing arts, pharmacists, mental health specialists, nutritionists, and substance abuse treatment personnel. If you do not know the name of a Healthcare Provider, identify the Healthcare Facility.

Healthcare Facility: All hospitals, clinics, outpatient facilities, health departments, medical offices, laboratories, substance abuse treatment centers, and all other locations at which medical care, treatment, or medication is provided by any Healthcare Provider.

Complaint: The operative complaint filed in your case, whether an original, amended or subsequent complaint.

Statin: Any HMG-CoA reductase inhibitor, whether brand or generic, and including any combination statin medication, including, but not limited to:

- Lipitor, Atorlip, Torvast, Lipvas, Sortis, Torvacard, Totalip, Tulip, Stator, Atoris, Mactor (atorvastatin calcium)
- Zocor, Lipex, Simcard, Simlup, Simvotin, Denan, Liponorm, Sinvacor, Sivastin, Lipovas, Lodales, Zocord, Zimstat, Simvahexal, Simvastatin-Teva, Simvacor, Simvaxon, Simovil (simvastatin)
- Crestor (rosuvastatin)
- Baycol, Lipobay (Cerivastatin)
- Lescol, Lescol XL, Canef, Vastin (Fluvastatin)
- Mevacor (Lovastatin)
- Altroprev (Lovastatin)
- Compactin (Mevastatin)
- Livalo, Pitava (Pitavastatin)
- Pravachol, Selektine, Lipostat (Pravastatin)
- Vytorin, Inegy (Simvastatin and Ezetimibe)
- Advicor (Lovastatin and Niacin)
- Caduet (Atorvastatin and Amlodipine Besylate)
- Simcor (Simvastatin and Niacin)
- Juvisync (Sitagliptin and Simvastatin)
- Liptruzet (Ezetimibe and Atorvastatin)

EXHIBIT B

MANDATORY DISCLOSURES

A. Authorizations: Please sign and attach to this Fact Sheet the authorizations for the release of records appended hereto, to the extent that you have not already provided them.

B. Documents in your possession: If you have any of the following materials in your custody or possession, or if they are in the possession, custody or control of your lawyers, please attach a copy to this Fact Sheet. If you claim a legal privilege regarding any document or item listed below, please attach a privilege log to your fact sheet.

1. If Plaintiff has received disability benefits in connection with any of the medical conditions alleged in this lawsuit, produce documents in your possession which reflect payment of these benefits, including, but not limited to, worker's compensation, unemployment benefits, Social Security, or any other available disability supplement or support of any kind.

2. Copies of all medical records, reports, test results, bills, and any other documents from physicians, healthcare providers, hospitals, labs, test centers, insurance companies, or others who have provided treatment to the Plaintiff during the last twenty (20) years, or that Plaintiff otherwise identified in this Fact Sheet.

3. Copies of all documents related to any form of dietary, nutritional, or weight-control treatment, counseling, program, system, regimen, supplement, or medication that the Plaintiff has used or received from ten (10) years prior to diabetes diagnosis until the present.

4. If the Plaintiff is making a claim for lost wages in this case, copies of all employment records and tax returns of the Plaintiff for the period beginning three (3) years prior to Plaintiff's type 2 diabetes diagnosis through the end of the period of the wage loss claim.

5. Copies of all records evidencing the Plaintiff's use of any statin medication, including without limitation Lipitor or atorvastatin calcium, and including, but not limited to, prescriptions, receipts, pharmacy or payment records, insurance documents, drug containers, bottles, labels packages, package inserts, drug monographs, pharmacy tear-sheets, warnings, instructions or other records of use.

6. Copies of all records or documents reflecting the Plaintiff's use of any prescribed or over-the-counter medication or drug during the last twenty (20) years.

7. A copy of the Plaintiff's diary, journal, calendar, or daily note entries for the last twenty (20) years that memorialize, describe, refer to, or in any way relate to Plaintiff's medical condition, Plaintiff's use of Lipitor or atorvastatin, or the circumstances or events in the lawsuit, including any alleged injuries or damages.

8. Any articles, medical literature, Internet research, correspondence, or notes relating to diabetes or statins, excluding any privileged materials or documentation.

9. Any and all documents that reflect or describe Plaintiff's impairment of or limitations on activities resulting from Plaintiff's diabetes or any other injury allegedly caused by Plaintiff's ingestion of Lipitor or atorvastatin calcium.

10. Any and all photographs, videos, or audio recordings (not work product or materials prepared in anticipation of litigation), taken specifically to identify or to depict injuries or damages caused by Lipitor or atorvastatin calcium, or which in fact depict the injuries or damages caused by Lipitor or atorvastatin calcium.

11. Copies of letters testamentary or letters of administration relating to Plaintiff's status as Plaintiff (if applicable).

12. Copies of Plaintiff-Decedent's death certificate and autopsy report (if applicable).

13. Any release, covenant not to sue, or settlement paper that relates to any pleading you have filed in this matter or to the events or injuries alleged, including those related to any other lawsuit, to the extent their production is not prohibited by a confidentiality provision. To the extent that any document has been withheld on the basis that its production is prohibited by a confidentiality order, please describe the document.

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508

Name and address of the person or provider authorized to make the requested disclosure:

Provider: _____

Address: _____

_____

_____

Patient name: _____ Date of Birth: _____

Social Security Number: _____

I authorize the disclosure of all protected **medical and/or insurance records** 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, including the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, phone notes, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and letters or 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/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 records of any samples of prescription medicines provided.
- Information regarding HIV/AIDS.

This authorization does not permit you to disclose anything other than the documents and records described above to any of the individuals or entities identified below. This authorization DOES NOT permit disclosure of psychiatric, psychological, and/or substance abuse records. I authorize you to release the protected health information to the following, who have agreed to pay reasonable charges made by you to supply copies of such records:

Mara Cusker Gonzalez
Quinn Emanuel Urquhart & Sullivan LLP
51 Madison Avenue, 22nd Floor
New York, NY 10010

Amanda S. Kitts
Nelson Mullins Riley & Scarborough, LLP
1320 Main Street, 17th Floor
Columbia, SC 29201

Designated Litigation Record Retrieval Company:

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I acknowledge the right to revoke this authorization by writing to the attorney at the above-referenced address. 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 redisclosure by the recipient and no longer be protected under 45 CFR 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 remains in effect for the duration of my litigation involving Pfizer Inc.

_____ _____

Signature of Patient or Personal Representative Dated

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Patient

AUTHORIZATION AND RELEASE
FOR INSURANCE RECORDS AND REPORTS

Name and address of the insurance company or entity authorized to make the requested disclosure:

Name: _____

Address: _____

_____

_____

Insured's Name: _____ Date of Birth: _____

Social Security Number: _____

I authorize all holders of **insurance records or reports** to furnish copies of any and all recorded information, including by way of example, but not limited to the following:

all applications for insurance coverage and renewals; insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; physician, hospital, and dental reports, prescriptions, correspondence, test results, radiological films and any other medical records submitted for claims review purposes; claims records; records of all litigation; and all other records of any kind concerning or pertaining to the Insured.

This authorization does not permit you to disclose anything other than the documents and records described above to any of the individuals or entities identified below. This authorization DOES NOT permit disclosure of psychiatric, psychological, and/or substance abuse records. I authorize you to release the protected insurance records and reports to the following, who have agreed to pay reasonable charges made by you to supply copies of such records:

Mara Cusker Gonzalez
Quinn Emanuel Urquhart & Sullivan, LLP
51 Madison Avenue, 22nd Floor
New York, NY 10010

Amanda S. Kitts
Nelson Mullins Riley & Scarborough, LLP
1320 Main Street, 17th Floor
Columbia, SC 29201

Designated Litigation Record Retrieval Company:

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I acknowledge the right to revoke this authorization by writing to the attorney at the above-referenced address. 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 redisclosure by the recipient and no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization remains in effect for the duration of my litigation involving Pfizer Inc.

_____ _____
Signature of Insured or Personal Representative Dated

_____
Name of Insured or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Insured

AUTHORIZATION AND RELEASE
FOR EMPLOYMENT RECORDS

Name and address of the employer authorized to make the requested disclosure:

Name: _____

Address: _____

_____

_____

Employee name: _____ Date of Birth: _____

Social Security Number: _____

I authorize all holders of **employment records** to furnish copies of any and all recorded information, including by way of example, but not limited to the following:

all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, disciplinary records, workers' compensation files; all hospital, physician, clinic, infirmary, nurse, and dental records; x-rays, test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; reasons for termination or leaving; and any other records concerning employment with the above-named institution.

This authorization does not permit you to disclose anything other than the documents and records described above to any of the individuals or entities identified below. This authorization DOES NOT permit disclosure of psychiatric, psychological, and/or substance abuse records. I authorize you to release the protected employment records to the following, who have agreed to pay reasonable charges made by you to supply copies of such records:

Mara Cusker Gonzalez
Quinn Emanuel Urquhart & Sullivan, LLP
51 Madison Avenue, 22nd Floor
New York, NY 10010

Amanda S. Kitts
Nelson Mullins Riley & Scarborough, LLP
1320 Main Street, 17th Floor
Columbia, SC 29201

Designated Litigation Record Retrieval Company:

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I acknowledge the right to revoke this authorization by writing to the attorney at the above-referenced address. 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 redisclosure by the recipient and no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization remains in effect for the duration of my litigation involving Pfizer Inc.

_____ _____

Signature of Employee Dated

_____

Name of Employee

AUTHORIZATION AND RELEASE
FOR EDUCATIONAL RECORDS

Name and address of the educational institution authorized to make the requested disclosure:

Name: _____

Address: _____

_____

_____

Student Name: _____ Date of Birth: _____

Social Security Number: _____

I authorize all holders of **educational records** to furnish copies of any and all recorded information, including by way of example, but not limited to the following:

all school records including application and admission paperwork, attendance records, transcripts, report cards, diplomas, health and physical examination records, immunization records, nurses notes, disciplinary records, correspondence and any and all other information and records pertaining to the above individual.

I authorize you to release the protected educational information to the following, who have agreed to pay reasonable charges made by you to supply copies of such records:

Mara Cusker Gonzalez
Quinn Emanuel Urquhart & Sullivan, LLP
51 Madison Avenue, 22nd Floor
New York, NY 10010

Amanda S. Kitts
Nelson Mullins Riley & Scarborough, LLP
1320 Main Street, 17th Floor
Columbia, SC 29201

Designated Litigation Record Retrieval Company:

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_____

I acknowledge the right to revoke this authorization by writing to the attorney at the above-referenced address. 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 redisclosure by the recipient and no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization remains in effect for the duration of my litigation involving Pfizer Inc.

_____

Signature of Student or Personal Representative Dated

_____

Name of Student or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Student

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