IN THE UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

EASTERN DIVISION

IN RE: E. I. DU PONT DE NEMOURS AND COMPANY C-8 PERSONAL INJURY LITIGATION

CASE NO. 2:13-md-2433

JUDGE EDMUND A. SARGUS, JR.

MAGISTRATE JUDGE ELIZABETH P. DEAVERS

**This document relates to: ALL ACTIONS.**

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**CASE MANAGEMENT ORDER NO. 4**

**Plaintiff Fact Sheets and Records Authorizations**

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1. The Court hereby issues the following Case Management Order to govern the form, procedure, and schedule for the completion and service of Plaintiff Fact Sheets ("PFS") and the execution of authorizations for the release of certain records.

## I. Scope of Order

2. This Order applies to all Plaintiffs and their counsel in: (a) all actions transferred to *In Re: E. I. du Pont de Nemours and Company C-8 Personal Injury Litigation* ("MDL 2433") by the Judicial Panel on Multidistrict Litigation ("JPML") pursuant to its Order of April 8, 2013; (b) all related actions originally filed in or removed to this Court; and (c) any "tag-along" actions transferred to this Court by the JPML pursuant to

Rules 6.2 and 7.1 of the Rules of Procedure of the Panel, subsequent to the filing of the final transfer order by the Clerk of this Court (collectively "Member Actions").

3. This Order shall not limit or otherwise affect the procedures or timing of any additional MDL discovery (including depositions) beyond that which is described herein. Such additional discovery shall be carried out in accordance with the applicable Rules of Civil Procedure and will be the subject of a subsequent CMO.

**II. Plaintiff Fact Sheets**

4. The form PFS that shall be used in MDL 2433 and all Member Actions is attached as Exhibit 1. In accordance with the schedule set forth below, every Plaintiff in each Member Action shall:

a. complete and sign a PFS;

b. serve the completed PFS upon counsel for Defendant E. I. du Pont de Nemours and Company ("Defendant") in the manner described in Section IV below;

c. produce to Defendant all responsive, non-privileged documents in his or her possession, custody, or control that are requested in the PFS;

d. provide the records authorizations referenced below; and

e. serve courtesy copies upon the members of the Plaintiffs Steering Committee ("PSC") in the manner described in Section IV below.

5. In completing the PFS, every Plaintiff is required to provide Defendant with a PFS that is substantially complete in all respects. For a PFS to be "substantially complete in all respects," the responding Plaintiff must answer every question contained in the PFS to the best of his or her ability and leave no blanks, even if he or she can

only answer the question in good faith by indicating "not applicable," "N/A," or "I don't know."

6. Verification: Each Plaintiff's completed PFS shall be signed by the Plaintiff and treated as answers to interrogatories and responses to requests for production of documents under Fed. R. Civ. P. 33 and Fed. R. Civ. P. 34, respectively. The interrogatories and requests for production in the PFS shall be answered without objection as to relevance or the form of the question, though Plaintiffs' counsel reserve the right to raise any valid objections, including as to verification of document productions, prior to trial as provided in future orders. This section does not prohibit a Plaintiff from withholding or redacting information from medical or other records provided with the PFS based upon a recognized privilege.

7. Fact Sheet Deficiency Dispute Resolution: If Defendant disputes the sufficiency of any response(s) in a PFS, Defendant's Counsel shall notify the PSC, in writing, of the purported deficiencies via email to (a) C8@cwcd.com on behalf of the PSC and (b) such Plaintiff's individual representative counsel, allowing such Plaintiff an additional fourteen (14) days to correct the alleged deficiency. Defendant's email shall identify the case name, docket number, and purported due date(s), and include sufficient detail regarding the alleged deficiency for the parties to meet and confer, if necessary. Should the subject Plaintiff fail to cure the stated deficiencies or assert objections to the same, or otherwise fail to provide responses that are substantially complete in all respects (including the requested documents and signatures on all applicable authorizations) within fourteen (14) days of such notice, Defendant may request a meet and confer on any outstanding issues within seven (7) days and may

then file a Motion to Compel and seek an Order to Show Cause why the case should not be dismissed if no resolution is reached. Any such filing shall be served on the contact for the PSC and the subject Plaintiff's individual representative counsel, with any response to such filing to be submitted within fourteen (14) days following the date of service. Any such motion shall describe the parties' efforts to meet and confer regarding the alleged deficiencies in the PFS.

8. Notice of Delinquent Fact Sheets: If Defendant believes that a particular PFS is past due under this Order, Defendant shall send written notice via email to (a) C8@cwcd.com on behalf of the PSC and (b) such Plaintiff's individual representative counsel, allowing such Plaintiff an additional fourteen (14) days to serve a PFS that is substantially complete in all respects. Upon receipt of such notice, the PSC and/or counsel for the subject Plaintiff shall promptly confer with Defendant's counsel, and state the reason for the failure to provide the PFS. To the extent a dispute remains after the counsel confer, it may be raised with the Court for resolution.

9. Each Plaintiff shall remain under a continuing duty to supplement the information provided in his or her PFS, if needed, throughout the litigation, in a manner consistent with the provisions of Civil Rule 26(e).

**III. Records Authorizations**

10. (Non-Mental Health) Medical Authorizations: Each Plaintiff who completes a PFS in accordance with the preceding paragraphs of this Order shall also produce an Authorization to Release Health Information for each (non-mental health) medical provider (including insurers and pharmacies) listed in the PFS. The Health Information

Authorization that shall be used is attached hereto as Exhibit 2 and shall be served on Defendant's Counsel in accordance with the provisions of this Order.

11. Mental Health Medical Authorizations: Each Plaintiff who completes a PFS in accordance with the preceding paragraphs of this Order and who (a) also asserts or alleges a psychiatric injury, condition or other type of mental health damage, including emotional distress, induced by a PFOA probable-link disease, and (b) has undergone specific medical treatment related to such injury, condition or damage, shall, in addition to the above-referenced (non-mental health) medical provider releases, serve an original signed authorization for the release of medical records from each mental health care provider identified in the PFS related to such claimed condition, treatment, and/or damage. The Mental Health Records Authorizations that Plaintiffs shall complete in such cases is attached as Exhibit 3 and shall be served on Defendant's Counsel in accordance with the provisions of this Order.

12. Employment Authorizations: Each Plaintiff who completes a PFS in accordance with this Order and who alleges past or future lost earnings as a component of damages must also serve upon Defendant a completed Employment Records Authorization for each employer identified in the PFS with whom such Plaintiff was employed during the year(s) in question. The form Employment Records Authorization is attached hereto as Exhibit 4 and shall be served on Defendant's Counsel in accordance the provisions of this Order. By providing such Employment Records Authorizations, such Plaintiffs who provide those forms are expressly consenting to the release of their relevant earnings information through the production of W2's, 1099's, or other compensation information for the specific years in question. Additionally,

regardless of whether past or future lost earnings have been alleged, where work environment factors, health conditions, or injuries may reasonably relate to a Plaintiff's claim(s), Defendant may request an Employment Records Authorization from such Plaintiff for the particular place(s) of employment at issue by notifying that individual Plaintiff's counsel of record and the PSC. In the event of an objection, all reasons and bases must be expressly stated in writing, after which the Parties shall meet and confer in a good faith effort to resolve such objection(s). Following such efforts, any remaining disputed issues may be brought before the Court for resolution.

13. Water Company/Utility Records Authorizations: Each Plaintiff who completes a PFS in accordance with the preceding paragraphs of this Order shall also produce an Authorization for Release of Customer Records for each residential water provider listed in the PFS. The Water Company/Utility Records Authorization to be used is attached hereto as Exhibit 5 and shall be served on Defendant's Counsel in accordance with the provisions of this Order.

14. "Special" Authorizations: If any health care provider, employer, or other custodian of health records: (a) requires a specific form of authorization that is different than the authorizations referenced in and attached to this Order; (b) requires an updated or more recently-executed authorization than those already provided by a Plaintiff; (c) requires a notarized authorization; or (d) requires an original signature, Defendant shall notify Plaintiff's representative counsel and the PSC of such requirement(s) by electronic means, and the referenced Plaintiff shall, within twenty one (21) days of such notice having been given, either produce an executed authorization or object in writing. In the event of an objection, all reasons and bases must be expressly

stated in writing, and the parties shall meet and confer in a good faith effort to resolve such objection(s). Following such efforts, any remaining disputed issues may be brought before the Court for resolution.

15. Requests for Additional Authorizations: In the event that Defendant seeks any additional authorization(s) from a Plaintiff, either (a) as a result of Defendant having discovered specific medical providers, mental health providers, water providers, or employers that were not previously identified by such Plaintiff; or (b) in order to obtain documents in addition to those for which production is expressly provided in the above-referenced authorizations, Defendant shall submit such additional authorization request(s) to Plaintiff's representative counsel and the PSC, after which the referenced Plaintiff shall, within twenty one (21) days, either produce an executed authorization or object to the same. In the event of an objection, all reasons and bases must be expressly stated in writing, and the parties shall meet and confer in a good faith effort to resolve such objection(s). Following such efforts, any remaining disputed issues may be brought before the Court for resolution.

16. *Ex Parte* Physician Communications: Defendant and its counsel/authorized agents shall not conduct, engage in, nor authorize any *ex parte* communications, beyond what is reasonably necessary to facilitate the ordering and/or obtaining of medical records for any particular Plaintiff with any Plaintiff's treating physicians without advance notice to and pre-approval of the PSC and/or a subject Plaintiff's representative counsel. Should the parties be unable to reach agreement about those communications, Defendant and its counsel shall refrain from any such contact until such time as the Court has entered an appropriate order.

## IV. Service and Confidentiality

17. Each Plaintiff in a Member Action that is pending as of the entry of this Order shall have until December 1, 2013, to serve and produce to Defendant a completed PFS, signed and dated authorizations, and all responsive, non-privileged documents requested in the PFS that are in his or her possession, custody, or control. For any Plaintiff in a Member Action that is not pending in this Court as of the entry of this Order, the completed PFS, signed and dated authorizations, and all other responsive, non-privileged documents requested in the PFS that are in the Plaintiff's possession, custody, or control shall be produced by no later than 45 days after service of the Answer.

18. Plaintiffs shall serve the completed PFS and authorizations upon Defendant by emailing them to the following three lawyers, with return read receipt, at the following email addresses: (a) Damond Mace: damond.mace@squiresanders.com; (b) Craig Woods: craig.woods@squiresanders.com; and (c) Aaron Brogdon: aaron.brogdon@squiresanders.com. This shall constitute effective service of the PFS upon Defendant.

19. Concurrent with service to Defendant, Plaintiffs shall serve the completed PFS and authorizations upon the PSC by emailing them to the following: C8@cwcd.com.

20. Confidentiality: All information disclosed on a PFS, the PFS itself, and all related documents (including health care records and information) produced therewith or pursuant to an executed authorization shall be deemed confidential and treated as

"Confidential Information" pursuant to the terms of the Agreed Protective Order (Pretrial Order No. 4).

21. The PSC and Defendant's counsel shall meet and confer in a good faith effort to resolve any other disputes not specifically addressed above regarding the production of documents and/or the completion or service of a PFS and/or authorization(s). After such meet-and-confer efforts have been attempted in good faith, counsel for a party may bring any remaining dispute(s) before the Court.

IT IS SO ORDERED

Date: 10-23-2013

EDMUND A. SARGUS, JR.
UNITED STATES DISTRICT JUDGE

Date: October 23, 2013

ELIZABETH A. PRESTON DEAVERS
UNITED STATES MAGISTRATE JUDGE

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF OHIO**
**EASTERN DIVISION**

**IN RE: E. I. DU PONT DE NEMOURS AND COMPANY C-8 PERSONAL INJURY LITIGATION**

**Case No. 2:13-md-2433**

**JUDGE EDMUND A. SARGUS, JR.**
**Magistrate Judge Elizabeth P. Deavers**

**This document relates to: ALL ACTIONS.**

# EXHIBIT 1

# TO CASE MANAGEMENT ORDER NO. 4

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF OHIO**
**EASTERN DIVISION**

*MDL No. 2433*
*In Re: E. I. du Pont de Nemours and Company C-8 Personal Injury Litigation*

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In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If being filled out on behalf of someone who has died or is a minor, the questions relate to the deceased person or minor asserting claims in the lawsuit. If all the details requested cannot be recalled, please provide as much information as you can. The Plaintiff Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. *ADDITIONALLY, ALL ASPECTS OF THIS PLAINTIFF FACT SHEET ARE DESIGNATED AS CONFIDENTIAL AND COVERED BY THE AGREED PROTECTIVE ORDER (Docket No. 27).*

## I. CASE INFORMATION

1. **Caption:** _____ **Date:** _____
2. **Docket No.:** _____
3. **Plaintiff's Attorney and Contact information:**

_____
_____
_____
_____
_____
_____
_____

4. **Do you claim that you are a member of the class in *Jack W. Leach, et al. v. E. I. du Pont de Nemours and Company*, Civ. No. 01-C-608 (Cir. Ct. Wood Co. W. Va.)? (please select one): .....□Yes □ No**

## II. PLAINTIFF INFORMATION

**5. Name:** _____

**6. State any other name(s), including maiden names, that you have used and when:**

_____

_____

**7. Date of birth:** _____ **8. Place of birth:** _____

**10. Social Security No.:** _____

**11. Current Height:** _____ **12. Current Weight:**_____ **13. Gender:** _____

**14. If Currently Married:**

a. **Spouse's Name:** _____

b. **Spouse's date of birth:** _____ **c. Date of Marriage** _____

c. **Spouse Occupation:** _____

**15. Are you making a loss of Consortium claim in this case?.....□Yes □ No**

**16. If Previously Married:**

| Previous Spouse | Dates of Marriage |
|---|---|
| | |
| | |

**17. If you are completing this Fact Sheet in a representative capacity (on behalf of the estate of a deceased person or a minor), state:**

a. Your name and address: _____

_____

b. Your relationship to the deceased or the minor plaintiff:

_____

_____

c. Date of death (if applicable): _____

**18. Current and Prior Residences since 1950:**

| Current and Prior Addresses | Dates You Lived At This Address |
|---|---|
| | |
| | |
| | |
| | |
| | |

**19. Identify all schools you attended, starting from and including high school:**

| Name of School | Address | Dates of Attendance | Degree Awarded | Major or Primary Field |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**20. Please provide the following information for your employment history over the past ten (10) years:**

| Employer/Company | Address | Occupation/ Job Title/ Job Description | Dates of Employment |
|---|---|---|---|
| | | | |
| | | | |

**21. WITHOUT LIMITATION TO DATE RESTRICTIONS, please provide the following information for ANY employment you have had with duPont or at duPont's Washington Works Plant in Wood County, West Virginia:**

| Employer/Company | Address | Occupation/ Job Title | Dates of Employment |
|---|---|---|---|
| | | | |
| | | | |

**22. Have you ever served in a branch of the military? □Yes □ No**

**If yes, state the dates, the branch of service, duties, and highest rank/position attained:**

_____

_____

_____

**23. Have you ever been convicted of a felony or non-traffic related other crime? □Yes □ No**

**If yes, state the date, the court, and nature of the crime:**

_____

_____

_____

**24. If you ever filed a lawsuit or made a claim, other than the present lawsuit (and other than the original *Leach* class action lawsuit against DuPont involving this same C8 drinking water exposure), relating to any bodily injury or illness, explain where and when the lawsuit or claim was filed, the injuries claimed, and the names of the adverse parties:**

_____

_____

_____

_____

_____

**25. Have you ever had direct communication with DuPont, or any known employee of DuPont, regarding C8 contamination or injuries you claim you suffered because of alleged C8 exposure? .....□Yes □ No**

**If yes, please identify the form of communication, the approximate time of communication, the nature of the communication, and the individual(s) with whom the communication was made.**

_____

_____

_____

_____

_____

## III. ALLEGED C8 EXPOSURE

**26. If you have, since 1950, consumed drinking water from any of the following water sources for at least one year prior to December 4, 2004, list the approximate dates you used each such source: (check all that apply and list years)**

❒ City of Belpre (OH) from _____ to_____

❒ Little Hocking Water Association (OH) from_____ to_____

❒ Lubeck Public Service District (WV) from_____ to_____

❒ Mason County Public Service District (WV) from_____ to_____

❒ Village of Pomeroy (OH) from_____ to_____

❒ Tuppers Plains- Chester Water District (OH) from _____ to_____

❒ DuPont Washington Works Plant in Wood County, West Virginia from _____ to_____

❒ General Electric Plastics Plant in Wood County, West Virginia from _____ to_____

❒ Private Drinking Water Well _____ from _____ to_____

**27. Identify whether you have used for at least one year prior to December 4, 2004, any of the following sources of drinking water since 1950 and list the dates you used each source:**

| | Ever Used (Y/N)? | When used/Frequency of Use: | Where obtained: |
|---|---|---|---|
| Private Well | | | |
| Bottled Water | | | |
| Water at Job | | | |
| Other (explain) | | | |

**28. If you have ever used a water filter at your home for your drinking water, state the approximate dates used (if known), type (if known), manufacturer (if known), and who furnished/paid for the filter (if known):**

_____

_____

_____

**29. If you have ever participated in a bottled water replacement program, state the approximate dates you participated (if known), who sponsored/ran the program (if known), and who furnished/paid for the water you received from the program (if known):**

_____

_____

_____

## IV. DISEASE ATTRIBUTED TO C8 EXPOSURE

**30. Did you participate in the C-8 Heath Project? .....❒ YES ❒ No**
If yes, state how you participated, and provide your study or other identification number (if known). _____

_____

_____

**31. Do you claim to suffer from a PROBABLE LINK disease as established under the *Leach* settlement? .....❒ YES ❒ No** (check all that apply)

❒ Kidney Cancer ❒ Testicular Cancer ❒ Thyroid Disease

❒ Ulcerative Colitis ❒ Pregnancy-Induced Hypertension ❒ Preeclampsia

❒ Medically-Diagnosed High Cholesterol

**32. For each PROBABLE LINK disease checked above, list the disease, identify the DIAGNOSING doctor, that doctor's full address, and the approximate date of diagnosis.**

| DISEASE | DIAGNOSING DOCTOR (name and full address) | DATE OF DIAGNOSIS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**33. For each disease checked above, list the disease, identify the TREATING doctors or facility(ies) (*if different than the diagnosing doctor*), the full address, and the date(s) of treatment.**

| DISEASE | TREATING DOCTOR and/or FACILITY (name and full address *if different than the diagnosing doctor*) | DATE(S) OF TREATMENT |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**34. For each disease checked above**, identify the dates and locations of any blood tests, tissue samples, pathology reports, and/or any other medical testing that you know to be related to that specific disease.

| Type of Test | Approximate Date of Test | Test Provider (Doctor, Hospital, of Clinic) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**35. For each disease checked above, have you ever discussed with any of the diagnosing or treating physicians you identified above for such disease(s) whether they believed that such disease(s) may have been caused by C8/PFOA? .....❒ YES ❒ No**

If yes, (identify which disease if more than one) please provide the name(s) and address(es) and the approximate date(s) for any such physician who told you that your disease(s) may have been caused by C8/PFOA_____

_____

**36. List all medications taken over the 5 years before and 5 years after the date you claim that you were first diagnosed with the disease(s) for which you are making a claim in this lawsuit, and for each medication state the following:**

| Medication | Pharmacy | Prescribing Physician | Reason for Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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## V. PAST HISTORY

**37. Do you currently smoke? .....❒ YES ❒ No**

a. (If yes) How much? _____/day For how long? _____ yrs.

b. What brand do/did you smoke (or type if other than cigarettes)? _____

**38. Have you ever smoked? .....❒ YES ❒ No**

a. (If yes) How much? _____/day Approximate dates? _____

b. What brand do/did you smoke (or type if other than cigarettes)? _____

**39. Do you drink alcohol? .....❒ YES ❒ No**

a. (If yes) Approximately how often, how much, and what? _____

**40. Biological parents' names and current ages/dates of birth (if deceased, note date and cause):**

| Name | Date of Birth | If Deceased, **date of** death | If Deceased, cause **of** death |
|---|---|---|---|
| | | | |
| | | | |

**41. Biological siblings' names and current ages/dates of birth (if deceased, note date and cause):**

| Name | Date of Birth | If Deceased, date of death | If Deceased, cause of death |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**42. Biological children's names and current ages/dates of birth (if deceased, note date and cause):**

| Name | Date of Birth | If Deceased, **date** of death | If Deceased, cause of death |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**43. Identify whether you are aware if any of your biological relatives listed above has suffered from any of the disease(s) for which you are pursuing a claim in this case, and if yes, which relative, which disease(s), and approximately when did they first have this disease.**

_____

_____

_____

**44. Have you applied for workers' compensation, social security, or state or federal disability benefits within the past twenty (20) years? .....❒ YES ❒ No**

If Yes, then as to each application, separately state:

Date (or year) of application: _____

Type of benefits: _____

Nature of claimed injury/disability: _____

Period of disability: _____

Amount awarded: _____

Basis of your claim: _____

Claim/docket number (if applicable): _____Was claim denied? ❒ YES ❒ No

## VI. OTHER CLAIMS

**45. Are you claiming damages for lost wages: .....❒ YES ❒ No**

**If yes, for what time period: _____**

**If yes, what was your approximate wage during this time: _____**

**46. Are you claiming damages for out-of-pocket costs: .....❒ YES ❒ No**

**If yes, please provide a brief description of the costs incurred and/or claimed, including the approximate amount (if known):**

_____

_____

_____

_____

## VII. LIST OF ALL TREATING PHYSICIANS OR OTHER HEALTH PRACTICIONERS FOR THE PERIOD OF 10 YEARS *PRIOR TO THE FIRST DIAGNOSIS OF THE C8 PROBABLE LINKED DISEASE(S) IDENTIFIED ABOVE*, INCLUDING ALL PRIMARY CARE PHYSICIANS, FAMILY PHYSICIANS, OR ANY OTHER SPECIALISTS

**Primary Care Physicians or Family Physicians:**

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Other Physicians or Health Care Practitioners:**

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

**Name:** _____

**Address:** _____

**Approximate Period of Treatment:** _____

**Reason for Treatment:** _____

***Attach additional pages as needed to identify other health care providers you have seen.***

## AUTHORIZATIONS

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

## RECORDS

Provide those records in your possession which you used and/or relied upon to complete this form and/ or which support and/or relate to your claimed injuries or damages, your participation in the C-8 Health Project, or your claims for the C8 probable linked disease(s) alleged and/or described herein.

## VERIFICATION

I declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Plaintiff

_____
Print Name

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF OHIO**
**EASTERN DIVISION**

**IN RE: E. I. DU PONT DE NEMOURS AND COMPANY C-8 PERSONAL INJURY LITIGATION**

**Case No. 2:13-md-2433**

**JUDGE EDMUND A. SARGUS, JR.**
**Magistrate Judge Elizabeth P. Deavers**

**This document relates to: ALL ACTIONS.**

# EXHIBIT 2

# TO CASE MANAGEMENT ORDER NO. 4

**LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

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

TO:
Patient Name:
DOB:
SSN:

I, _____, hereby authorize you to release and furnish to: _
_____, copies of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.
* The undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.
* All employment or insurance records
* All workers' compensation claims or records, including any report of injury, all treatment records, and evidence of any benefits received/paid.

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

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

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

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

Print Name:_____(plaintiff/representative)
Signature: _____ _____ (Dated)

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF OHIO**
**EASTERN DIVISION**

**IN RE: E. I. DU PONT DE NEMOURS AND COMPANY C-8 PERSONAL INJURY LITIGATION**

**Case No. 2:13-md-2433**

**JUDGE EDMUND A. SARGUS, JR.**
**Magistrate Judge Elizabeth P. Deavers**

**This document relates to: ALL ACTIONS.**

# EXHIBIT 3

# TO CASE MANAGEMENT ORDER NO. 4

**LIMITED AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION**
**(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)**

TO:
Patient Name:
DOB:
SSN:

I, _____, hereby authorize you to release and furnish to: _
_____, copies of the following information:

* All mental health records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said mental health records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.
* "Psychotherapy notes" as defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.
* All employment or insurance records
* All workers' compensation claims or records, including any report of injury, all treatment records, and evidence of any benefits received/paid.

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

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

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

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

Print Name:_____(plaintiff/representative)
Signature: _____ _____ (Dated)

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF OHIO**
**EASTERN DIVISION**

**IN RE: E. I. DU PONT DE NEMOURS AND COMPANY C-8 PERSONAL INJURY LITIGATION**

**Case No. 2:13-md-2433**

**JUDGE EDMUND A. SARGUS, JR.**
**Magistrate Judge Elizabeth P. Deavers**

**This document relates to: ALL ACTIONS.**

# EXHIBIT 4

# TO CASE MANAGEMENT ORDER NO. 4

# AUTHORIZATION FOR RELEASE OF EMPLOYEE RECORDS

TO: _____
*(Current or Former Employer)*

_____
*(Address)*

_____
(City)

EMPLOYEE: [plaintiff and/or employee name]
ADDRESS: [plaintiff address]

**This authorization is being forwarded by, or on behalf of, attorneys for the defendant in an ongoing legal action for injuries allegedly sustained as a result of defendant's conduct.** I, _____, request and authorize the above-named company to release the information specified below to the persons or organizations named on this request for the purposes of damages or claim evaluation or litigation.

Information Requested:

Any and all information and records regarding my current or past employment, including but not limited to the following:

- Employment application(s);
- Payroll authorization form(s);
- Notice(s) of commendation, warning, discipline, and/or termination;
- Notices of layoff, leave of absence and vacation;
- Notices of wage attachment or garnishment;
- Education and training notices and records;
- Performance appraisals/reviews;
- Attendance records; and
- Payroll records.

The foregoing authority shall continue in force until revoked by me in writing. A photostatic or electrostatic copy hereof shall have the same authority as the original.

Authorization:

I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This consent will automatically expire within one year of the date of execution below, but in any event if revoked in writing by employee.

Other Conditions:

A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Release To:

Aaron T. Brogdon
SQUIRE SANDERS (US) LLP
2000 Huntington Center
41 South High Street
Columbus, Ohio 43215
(614) 365-2700

Counsel for E. I. du Pont de Nemours and Company

Important:

Copies of any and all documents or information provided to the law firm listed above must also be sent to the following:

[Plaintiff's counsel]
[Address of plaintiff's counsel]

Counsel for Plaintiff.

DATE: _____ _____
[plaintiff/employee]

STATE OF _____)

COUNTY OF _____)

The foregoing instrument was acknowledged before me this ___day of _____, 2013, by [plaintiff/employee], who [ ] is personally known to me or [ ] has produced _____as identification

_____
Notary Public

Type/Print Name: _____
Commission Number: _____

(SEAL)

Commission Expires:

_____

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF OHIO**
**EASTERN DIVISION**

**IN RE: E. I. DU PONT DE NEMOURS AND COMPANY C-8 PERSONAL INJURY LITIGATION**

**Case No. 2:13-md-2433**

**JUDGE EDMUND A. SARGUS, JR.**
**Magistrate Judge Elizabeth P. Deavers**

**This document relates to: ALL ACTIONS.**

# EXHIBIT 5

# TO CASE MANAGEMENT ORDER NO. 4

# AUTHORIZATION FOR RELEASE OF CUSTOMER RECORDS

TO: _____
*(Water Company/Utility Name)*

_____
*(Address)*

_____
(City)

CUSTOMER: [plaintiff and/or account holder name]
ADDRESS: [plaintiff address]

I, _____, request and authorize the above-named company/utility to release the information specified below to the organizations named on this request for the purposes of damages or claim evaluation or litigation.

Information Requested:

1. Any and all communications or correspondence with [plaintiff/account holder name] which specifically reference PFOA;

2. Any and all documents relating to water service provided to [plaintiff/account holder name] and/or [plaintiff address], including any and all documents regarding quantity/volume of water provided or consumed;

3. Any and all documents relating to account billing and/or payments received from [plaintiff/account holder name];

4. Any and all documents that reflect or refer to the account number or other identifying information associated with the account of [plaintiff/account holder name] or [plaintiff address]; and

5. Any other records concerning the file/account of [plaintiff/account holder name].

Authorization:

I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This consent will automatically expire within one year of the date of execution below, but in any event if revoked in writing by employee.

Other Conditions:

A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Release To:

Aaron T. Brogdon
SQUIRE SANDERS (US) LLP
2000 Huntington Center
41 South High Street
Columbus, Ohio 43215
(614) 365-2700

Counsel for E. I. du Pont de Nemours and Company

Important:

Copies of any and all documents or information provided to the law firm listed above must also be sent to the following:

[Plaintiff's counsel]
[Address of plaintiff's counsel]

Counsel for Plaintiff.

DATE: _____ _____
[plaintiff/account holder]

STATE OF _____)

COUNTY OF _____)

The foregoing instrument was acknowledged before me this ___day of _____, 2013, by [plaintiff/account holder], who [ ] is personally known to me or [ ] has produced _____as identification

_____
Notary Public

Type/Print Name: _____
Commission Number: _____

(SEAL)

Commission Expires:

_____