HIPAA RELEASE FORM FOR
ENDO PI TRUST DISTRIBUTION PROCEDURES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claimant Name:_____ **Date:**_____

Date of Birth:_____ **Soc. Sec. No.**_____

1. The following individuals or organizations are authorized to disclose my health records to the parties specified below in section #4:

_____
_____
_____
_____
_____

(Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your PI Claim. If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties):

2. The type and amount of information to be used or discloses is as follows:

The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:

Dates of Services - From:_____ To: _____

(Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your PI Claim. If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges).

3. I understand that the information in my health records 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, as well as treatment for alcohol and drug abuse.

4. The health information may be disclosed to and used by the following individual and/or organization:

    a. Endo Opioid Personal Injury Trust; Endo NAS Personal Injury Trust; Endo Future Personal Injury Trust
    b. Edgar C. Gentle, III., of Gentle, Turner & Benson, LLC, as the Trustee and Claims Administrator of the Endo Personal Injury Trusts listed above in 4.a.
    c. MASSIVE: Medical and Subrogation Specialists

5. I understand I have the right to revoke this authorization at any time. I understand 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 10 years after the date that I sign it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under the Endo Personal Injury Trust Distribution Procedures. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand 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 or HIPAA. If I have questions about disclosure of my health information, I can contact the parties listed above in section #4.

_____ _____

Patient or Legal Representative Date

_____

Relationship to Patient (If signed by Legal Representative)