



clarklovehutson

A Professional Limited Liability Company

3M Company (“3M”) Combat Arms™ Earplugs Claim

Required Medical Authorization Forms

This file contains the required Medical Authorization Forms necessary for us to order your medical records, which are critical to prove your case.

Please follow the following instruction carefully. We need you to completely ***fill out ONLY the highlighted section*** of the forms, sign where indicated, but ***DO NOT DATE*** them. Please return them to our office using one of the following methods:

1. Mail the completed authorizations to our office;

Clark, Love & Hutson
Attn: 3M Department
440 Louisiana St, Suite 1700
Houston, TX 77002

2. Scan & Email the completed authorizations to our office at ***3Mearplugs@triallawfirm.com***; or

3. Fax a legible copy of the authorizations to 713-759-1217.

If you have any question, please do not hesitate to contact us at ***1-888-278-4500*** or by email at ***3Mearplugs@triallawfirm.com***.

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

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

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH			
5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that ALL service be shown below.)						
	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
b. RESERVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
c. STATE NATIONAL GUARD	-			<input type="checkbox"/>	<input type="checkbox"/>	

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

7. **DID THIS PERSON RETIRE FROM MILITARY SERVICE?** NO YES

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

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

DD Form 214 or equivalent. Year(s) in which form(s) issued to veteran: _____
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. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: I want a **DELETED** copy.

Medical Records Includes Service Treatment Records, Health (outpatient) and Dental Records. **IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided:** _____

Other (Specify): _____

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

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

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER NAME:** _____

2. I am the **MILITARY SERVICE MEMBER OR VETERAN** identified in Section I, above. I am the **VETERAN'S LEGAL GUARDIAN (MUST submit copy of Court Appointment) or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)**

I am the **DECEASED VETERAN'S NEXT-OF-KIN (MUST submit Proof of Death. See item 2a on instruction sheet.)** OTHER

(Specify type of Other)

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

Clark, Love & Hutson, PLLC

Name
440 Louisiana Street Suite 1700
Street Apt.
Houston, TX 77002
City State Zip Code

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

Signature Required - Do not print _____ **Date** _____

Daytime phone _____ Fax Number _____

Email address _____

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

MEDICAL AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

PATIENT INFORMATION		
First Name:	Middle Initial:	Last Name:
Alias/Maiden Name(s):		Home Phone:
Home Address:		
Date of Birth:	Social Security Number:	
FACILITY INFORMATION		
Name: PLEASE LEAVE THIS SECTION BLANK		
Date Begin: DO NOT DATE	Date End: DO NOT DATE	
Information to be disclosed: <input type="checkbox"/> Operative Report <input type="checkbox"/> Intraoperative Nurse Notes <input type="checkbox"/> Most Recent History & Physical <input type="checkbox"/> Itemized Billing Statement <input type="checkbox"/> Doctor's Notes <input type="checkbox"/> Pharmacy Records <input type="checkbox"/> Complete Chart <input type="checkbox"/> Test Results <input type="checkbox"/> Insurance Records		
Other: _____		

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, for the purpose of: "at the request of the individual" to the following recipients or any of their representatives:

Clark, Love & Hutson, PLLC | 440 Louisiana, Suite 1700, Houston, Texas 77002 | Telephone: 713-757-1400 | Facsimile: 713-759-1217

This authorization shall also serve to permit a representative of **Clark, Love & Hutson, PLLC** to conduct a personal review of all medical information that you may have pertaining to the patient named above and to orally discuss this information with you.

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

This authorization shall remain in full force and effect until it expires three years from the date set forth below. **PHOTOCOPIES OF THIS RELEASE ARE VALID.**

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 by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that you may transmit my protected health information electronically in the course of my representation.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

Signature: _____
(Patient and/or Legal Representative)

Date: _____ DO NOT DATE



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: 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 Act. 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 the instructions, gather the necessary facts and fill out this form. 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 the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA 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 system of records notices identified as 24VA10P2 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Address of VA Health Care Facility)

LAST NAME- FIRST NAME- MIDDLE INITIAL

LAST 4 SSN

DATE OF BIRTH

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

PURPOSE(S) OR NEED: Information is to be used by the individual for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify)

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- HEALTH SUMMARY (Prior 2 Years)
INPATIENT DISCHARGE SUMMARY (Dates):
PROGRESS NOTES:
SPECIFIC CLINICS (Name & Date Range):
SPECIFIC PROVIDERS (Name & Date Range):
DATE RANGE:
OPERATIVE/CLINICAL PROCEDURES (Name & Date):
LAB RESULTS:
SPECIFIC TESTS (Name & Date):
DATE RANGE:
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS:
FLU VACCINATION (Dose, Lot Number, Date & Location):
OTHER (Describe):

LAST NAME- FIRST NAME- MIDDLE INITIAL		LAST 4 SSN	DATE OF BIRTH
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT. I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization. <input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE <input type="checkbox"/> SICKLE CELL ANEMIA <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (HIV) I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure. <input type="checkbox"/> I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.			
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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that the VA health care provider'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.			
EXPIRATION: Without my express revocation, the authorization will automatically expire. <input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED <input type="checkbox"/> ON _____ (enter a future date other than date signed by patient) <input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____			
PATIENT SIGNATURE (Sign in ink)		DATE (mm/dd/yyyy)	
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)		DATE (mm/dd/yyyy)	
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT	
FOR VA USE ONLY			
TYPE AND EXTENT OF MATERIAL RELEASED			
DATE RELEASED		RELEASED BY:	