EXHIBIT A

IN RE: Vioxx® PRODUCTS LIABILITY LITIGATION

MDL Docket No. 1657

Plaintiff or Claimant: _____
(name)

AMENDED AND SUPPLEMENTAL PLAINTIFF PROFILE FORM

This Amended and Supplemental Plaintiff Profile Form ("ASPPF") is to be completed and served pursuant to the requirements of Pre-Trial Orders ("PTOs") 28 and 29.

Other than in Sections I (C) and VIII, those questions using the term "You" should refer to the person who used Vioxx. Please use the Additional Information pages, located at the end of this form, as necessary to fully answer these questions. Sources of Information must be completed by each plaintiff who used Vioxx or their personal representative. Section VIII must be completed by loss of consortium plaintiffs.

If you are completing this questionnaire in a representative capacity, please respond to all questions with respect to the person who used Vioxx, unless the question instructs you otherwise. Those questions using the term "You" refer to the person who used the Vioxx, unless you are instructed otherwise. If the individual is deceased, please respond as of the time immediately prior to his or her death, unless a different time period is specified. In filling out this form, please use the following definitions:

(1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, mental, emotional or psychological care or advice and any pharmacy, counselor, dentist, X-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician or other persons or entities involved in evaluation, diagnosis, care and/or treatment;

(2) "**document**" means any writing or record or any type, however produced and whatever the medium on which it was produced or reproduced, and includes, without limitation, the original and any non-identical copy (whether different from the original because of handwritten notes or underlying on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meeting, calendars, diaries, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, X-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings, or pictures of any kind of description.

I. CASE INFORMATION

A. Name of person completing this form: _____

B. Please state the following for the civil action or claim which you filed:

1. Case caption: _____

2. Case No.: _____

3. If Tolling Claimant, set forth the date you executed your Notice of Tolling Agreement: _____

4. Please state the name, address, and telephone number of the principal attorney representing you. If you are not represented by an attorney in this case, please state "none."

   Name: _____

   Firm name: _____

   City, State and Zip Code: _____

   Telephone number: _____

C. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person, or a minor, or incapacitated person), please complete the following:

1. Your name: _____

2. Social Security Number: _____

3. Any other names used or by which you have been known, including but not limited to maiden name: _____

4. Street Address: _____

5. City, State and Zip Code: _____

6. If you are serving in a representative capacity, state which individual or estate you are representing, and in what capacity you are representing the individual or estate:
   _____

7. If you were appointed as a representative by a court, state the:

   _____ _____
   Court Date of Appointment

8. Your relationship to deceased or represented person or person claimed to be injured: _____

9. If you represent a decedent's estate based on a decedent's death, state the date of death of the decedent and the address of the place where the decedent died: _____ _____

D. Claim Information:

1. Identify each bodily injury you claim resulted from your use of Vioxx: _____ _____ _____ _____

2. Identify the date(s) that you claim each injury occurred: _____ _____ _____

3. Who diagnosed the conditions? _____ _____ _____

4. Did you ever suffer the same type of injury(ies) prior to the date(s) set forth in Section I (D) (2)? Yes ____ No ____

   If "yes," please specify each prior injury, when it occurred and who diagnosed each prior injury at that time: _____ _____ _____

5. Do you claim that your use of Vioxx worsened a condition that you already had or had in the past? Yes ____ No ____

   If "yes," set forth the injury or condition; whether or not you had already recovered from that injury or condition before you took Vioxx; and the date of recovery, if any: _____ _____ _____ _____

E. Are you claiming damages for any psychological, psychiatric or other mental or emotional problem as a consequence of using Vioxx? Yes ____ No ____

   If "yes," describe each kind of injury you allege you suffered and when you allegedly suffered it: _____ _____ _____ _____

Also if "yes," did you seek treatment for these injuries?
Yes ____ No _____

If "yes," provide:

1. Name and address of each person who treated you:

   _____
   Name

   _____
   Address (if not otherwise provided)

2. Condition(s) for which treated: _____

3. When treated: From: _____ To: _____

4. Medications prescribed for each such condition: _____

Also if "yes," state whether you have experienced or been treated for any psychological, psychiatric or other mental or emotional problem prior to the physical injury you claim from Vioxx, including but not limited to panic attacks, anxiety, post traumatic stress disorder, depression, thoughts of hurting yourself or other people, schizophrenia, bipolar disorder, personality disorders (e.g., obsessive compulsive, paranoid, borderline, histrionic, other), generalized anxiety disorder, social phobia/anxiety disorder, post-traumatic stress disorder, depression, mania, poor sleep, poor concentration, suicidal thoughts/attempts, and drug abuse. Yes ____ No ____

If "yes," state:

5. Name and address of each person who treated you:

   _____
   Name

   _____
   Address (if not otherwise provided)

6. Condition(s) for which treated: _____

7. When treated: From: _____ To: _____

8. Medications prescribed for each such condition: _____

II. VIOXX® PRESCRIPTION INFORMATION

A. Who prescribed Vioxx for you? _____
_____
_____
_____

B. On which dates did you begin to take, and stop taking, Vioxx?
_____
_____

C. For what condition were you prescribed Vioxx?
_____
_____

D. Did you receive a prescription for Vioxx? Yes ____ No ____

If "yes," set forth the name(s) and address(es) of each pharmacy where you filled each Vioxx prescription: _____
_____
_____
_____

1. Did you renew your prescription for Vioxx? Yes ____ No _____

   If "yes," how many times? _____

E. Did you receive any samples of Vioxx? Yes ____ No ____

If "yes," for each provider, provide the following:

1. Identify the full name and address of person who provided you a sample of Vioxx:
   _____
   _____

2. Identify how many tablets of each dosage were provided: _____

3. Identify each date samples of each dosage were provided: _____
   _____

F. Which form of Vioxx did you take (check all that apply)?

_____12.5 mg Tablet (cream, round, MRK 74)
_____12.5 mg Oral Suspension
_____ 25 mg Tablet (round, yellow, MRK 110)
_____ 25 mg Oral Suspension
_____ 50 mg Tablet (round, orange, MRK 114)

G. How many times per day did you take Vioxx?

_____

H. Have you reviewed any written, televised or internet-based advertising or labeling materials regarding Vioxx? Yes ____ No ____

If "yes," state which written, televised or internet-based advertising or labeling materials you reviewed regarding Vioxx and when you reviewed such materials. _____

_____

_____

_____

I. Have you had discussions with any doctor about whether your claimed injury(ies) set forth in Section I (D), above, is related to the use of Vioxx? Yes ____ No ____

If "yes," provide the following:

1. Identify the doctor(s) with whom you had such discussions.

   _____

   Name

   _____

   Address (if not otherwise provided) *(If discussed with more than one doctor, please provide details in the Additional Information page located at the end of this form)*

J. State whether you requested that any doctor or clinic provide you with Vioxx or a prescription for Vioxx. Yes ____ No ____

K. Were you given any written instructions or warnings regarding the use of Vioxx? Yes ____ No ____

If "yes," state:

1. When the written instructions or warnings were given:

   _____

   _____

2. A description of the written warnings or instructions (e.g., package insert, patient product information, pharmacy handout, etc.): _____

   _____

   _____

3. Identify each person or entity from whom you received the warnings or instructions:

   _____

   _____

   _____

4. Approximate date you received the written instructions or warnings: _____

5. Summary of instructions/warnings received: _____
_____
_____

L. What other medications (including aspirin), if any, were you taking at the same time you were taking Vioxx?
_____
_____
_____
_____
_____

M. What other medications (including, but not limited to, aspirin, ibuprofen, naproxen, and Celebrex) have you taken for osteoarthritis, rheumatoid arthritis, or pain relief, and when did you take them? _____
_____
_____

1. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? ***If "yes,"*** list the type of adverse side effect, the medication you were taking and the date(s) on which you experienced the adverse side effect. _____
_____
_____
_____

2. Did you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking Vioxx? ***If "yes,"*** set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment. _____
_____
_____
_____

N. On what date, and in what city and state, did you first experience any symptoms you believe are related to the injury(ies) alleged in Section I (D) and what were those symptoms? _____
_____
_____
_____

O. Were there any witnesses to the symptoms identified in Section I (D)? ***If "yes,"*** state their names, addresses, phone numbers and relationships to you. _____
_____
_____
_____

P. When did you first contact a doctor or healthcare professional concerning the injury you allege in Section I (D) and whom did you contact? _____
_____
_____
_____

Q. If you were taken to a doctor or health care facility for the injury(ies) alleged in Section I (D), state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company that took you to the doctor or health care facility. _____
_____
_____

III. PERSONAL INFORMATION OF THE PERSON WHO USED VIOXX®

A. Last name: _____

First name: _____

Middle name or initial: _____

B. Any other names used of by which you have been known, including but not limited to maiden name: _____
_____

C. Social Security Number: _____

D. Driver's license number: _____ State issuing your license: _____

E. Date and place of birth: _____

F. Sex: Male ____ Female ____

G. Current street address: _____
_____

H. Identify each other address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one *(if you have not resided at another address in the last ten (10) years please state "none."):*

Address	**Dates of Residence**	
	From:	**To:**

I. Identify each high school, college, university or other educational institution (except grade school) you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

Institution	**Dates Attended**	**Course of Study**	**Diplomas & Degrees**

J. Employment Information.

1. Current employer (if not currently employed, last employer):

   Name of employer: _____

   Address: _____

   Dates of employment: From: _____ To: _____

   Occupation/Job duties: _____

2. List the following for each employer you have had in the last ten (10) years (not including any employer listed in Section III (J) (1) above):

   Name of employer: _____

   Address: _____

   Dates of employment: From: _____ To: _____

   Occupation/Job duties: _____

   Name of employer: _____

   Address: _____

   Dates of employment: From: _____ To: _____

   Occupation/Job duties: _____

   Name of employer: _____

   Address: _____

   Dates of employment: From: _____ To: _____

   Occupation/Job duties: _____

   Name of employer: _____

   Address: _____

   Dates of employment: From: _____ To: _____

   Occupation/Job duties: _____

K. Military Service Information

1. Have you ever served in any branch of the U.S. Military?
   Yes ____ No ____

   If "yes," please state:

   a. What branch and the dates of service: _____
      _____

   b. Were you discharged for any reason relating to your physical, psychiatric or emotional condition?
      Yes ____ No ____

If "yes," state what that condition was: _____
_____

2. Have you ever been rejected from military service for any reason relating to your health or physical condition?
Yes ____ No ____

If "yes," state what that condition was: _____
_____

3. Have you ever served in the military overseas?
Yes ____ No ____

If "yes," state location and dates: _____
_____

L. Insurance/Claim Information

1. Have you ever filed a worker's compensation claim? Yes ____ No ____

If "yes," please state:

a. Year claim was filed: _____

b. Court/State where claim was filed: _____

c. Claim/docket number, if applicable: _____

d. Nature of disability: _____

e. Period of disability: _____

f. Benefits received, if any: _____

g. Identify the full name and address of the entity most likely to have records concerning your claim: _____
_____
(If necessary, to describe more than one claim, please provide details in the Additional Information page located at the end of this form.)

2. Have you ever filed a social security disability claim (SSI or SSD)?
Yes ____ No ____

If "yes," please state:

a. Year claim was filed: _____

b. Where claim was filed: _____

c. Nature of disability: _____

d. Period of disability: _____

e. Benefits received, if any: _____

f. Identify the full name and address of the entity most likely to have records concerning your claim: _____

_____

(If necessary, to describe more than one claim, please provide details in the Additional Information page located at the end of this form.)

3. Have you ever been denied life insurance or medical insurance for reasons relating to your medical or physical condition? Yes ____ No ____

If "yes," state when, the name of the company and the company's stated reason for denial: _____

_____

_____

4. ***(Answer this question if you are claiming damages for mental or emotional distress.)*** Have you ever been denied life insurance or medical insurance for reasons relating to your mental or emotional condition? Yes ____ No ____

If "yes," state when, the name of the company and the company's stated reason for denial: _____

_____

5. Has any insurance or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning ten (10) years before your alleged injury through the present? Yes ____ No ____

If "yes," then as to each company, separately state:

Name of the company: _____

Address of the company: _____

The account/policy number or designation: _____

Dates of coverage: _____

When claim was made: _____

6. Have you ever been out of work for more than thirty (30) days for reasons related to your health? Yes ____ No ____

If "yes," identify the date you were out of work and the reason(s).

When: From: _____ To: _____

Reason: _____

7. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury? Yes ____ No ____

If "yes," please provide the following:

When the lawsuit or claim was made: _____

Court in which such action was filed: _____

Case caption: _____

Case name: _____

Civil action/Docket No.: _____

Name(s) of adverse parties: _____

Brief description of claims asserted: _____
_____

M. Have you ever been convicted or plead guilty of a crime? Yes ____ No ____

If "yes," identify where, when, and the crime: _____
_____

IV. FAMILY INFORMATION

A. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (i.e. divorce, annulment, death):
_____
_____
_____

B. Has your spouse filed a loss of consortium claim in this action? Yes ____ No ____

C. Has any parent, grandparent, child, or sibling ever been diagnosed with a problem or condition relating to the same organ or organ system identified in your answer to Section I(D)? Yes ____ No ____

If "yes," identify each such person below and provide the information requested.

1. Name: _____

   Current age (or age at death): _____

   Type of problem or condition: _____

   Age at problem or condition: _____

   If applicable, cause of death: _____

2. Name: _____

   Current age (or age at death): _____

   Type of problem or condition: _____

   Age at problem or condition: _____

   If applicable, cause of death: _____

3. Name: _____

   Current age (or age at death): _____

   Type of problem or condition: _____

   Age at problem or condition: _____

   If applicable, cause of death: _____

D. Provide the full name, address and age of each of your children. If you had no children, state *"none."* _____
_____
_____
_____
_____

E. If you are claiming the wrongful death of a family member, list any and all heirs of the decedent who have standing to assert a wrongful death claim. _____
_____
_____

F. If you are bringing a survivor cause of action, state whether you have been appointed as the decedent's personal representative authorized to prosecute the decedent's claims, and when and by whom you were so appointed: _____
_____
_____
_____

V. CURRENT MEDICAL CONDITION

A. Do you currently suffer from any physical injuries, illnesses or disabilities other than those you alleged are the result of your use of Vioxx in Section I (D)?
Yes ____ No ____

If "yes," please state the following for each injury, illness or disability:

1. Identify the injury, illness, or disability, their symptoms and date of onset:
_____
_____
_____

2. By whom first diagnosed:
_____ _____
Name Address
_____
Date of diagnosis

VI. MEDICAL BACKGROUND

A. Height: _____

B. Current Weight: _____

C. Weight at the time of the injury, illness or disability described in Section I (D): _____

D. Prescription Medicines

1. To the best of your knowledge, state whether you used any of the following from ten (10) years prior to the date of the injury you allege in Section I (D) through the present, check all medications you have used, state the first and last dates you took the medication, and identify the doctor that prescribed the medication.

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Angiotension Converting Enzyme ("ACE") Inhibitors: Altace: _____ Aceon: _____ Accupril: _____ Monopril: _____ Lotensin: _____ Capoten: _____ Vasotec: _____ Prinivil: _____ Zestril: _____ Univasc: _____ Mavik: _____ **Other:**				High blood pressure: _____ Heart disease: _____ Cardiomyopathy: _____ Previous heart attack: _____ Enlarged heart: _____ Kidney problems: _____ Diabetes: _____ **Other:**
Angiotension II Receptor Antagonists ("ARBs"): Cozaar: _____ Diovan: _____ Avapro: _____ Micardis: _____ Atacard: _____ **Other:**				High blood pressure: _____ Heart disease: _____ Cardiomyopathy: _____ Previous heart attack: _____ Enlarged heart: _____ Kidney problems: _____ Diabetes: _____ **Other:**
Beta Blockers: Inderal:_____ Lopresser:_____ Toprol:_____ Sectral:_____ Corgard:_____ Coreg:_____ Tenormin:_____ Timoptic:_____				High blood pressure:_____ Heart problems:_____ Previous heart attack:_____ Recurrent chest pain:_____ Migraine headaches:_____ Eye problems:_____ Panic disorders:_____ Social phobias:_____ **Other:**

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Betoptic:_____ Brevibloc:_____ Betapace:_____ Viskin:_____ **Other:**				
Calcium Channel Blockers: Norvasc:_____ Procardia:_____ Calan:_____ Cardizem:_____ Plendil:_____ Cardene:_____ Sular:_____ **Other:**				Recurrent chest pain:_____ Heart problems:_____ Raynaud's phenomenon:_____ Migraine headaches:_____ Esophageal (throat) spasm:_____ **Other:**
Alpha Blockers: Cardura:_____ Minipress:_____ Hytrin:_____ **Other:**				High blood pressure:_____ Benign prostatic hypertrophy (BPH):_____ Heart problems:_____ **Other:**
Diuretics: Hydrodiuril:_____ Hygroton:_____ Microx:_____ Lozol:_____ Lasix (furosemide):_____ Demadex:_____ Dyazide:_____ Aldactazide:_____ Moduretic:_____ **Other:**				High blood pressure:_____ Edema in legs (fluid):_____ Heart problems:_____ **Other:**

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Central Alpha Agonists: Catapres:_____ Tenex:_____ Aldomet:_____ Wytensin:_____ **Other:**				High blood pressure:_____ **Other:**
Other (please list): (can include combination pills, or any other pill thought be to prescribed for high blood pressure):				
Heart Medications: (other than ACE Inhibitors, ARBs, or high blood pressure medications already listed above) Digoxin (lanoxin):_____ Amrinone:_____ Primacor:_____ **Other:**				
Anticoagulants: Coumadin (warfarin):_____ Heparin or Low Molecular Weight Heparin:_____ **Other:**				Blood clot (DVT):_____ Atrial fibrillation:_____ Previous heart attack:_____ Prolonged hospitalization:_____ Suspected or proven pulmonary Embolism (PE):_____ Heart valve problems:_____ **Other:**

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Aspirin: 81mg: ___ 325mg: ___ Number of times taken each day _____				Prevention for heart attack:_____ Prevention for stroke and/or transient ischemic attack (TIA):_____ Rheumatoid arthritis:_____ Other pain syndromes:_____ Rheumatic fever:_____ Osteoarthritis:_____ Previous heart or other surgery:_____ **Other:**
Anti-Platelet Medications: (other than aspirin) Plavix:_____ Apo-Dipyridamole:_____ Ticlid:_____ **Other:**				Heart surgery:_____ Heart attack:_____ Catherization:_____ Stenting:_____ Chest pain at rest:_____ **Other:**
Cholesterol Lowering Drugs: Lipitor:_____ Zocor:_____ Pravachol:_____ Lescol:_____ Colestid:_____ Niacin:_____ Lopid:_____ **Other:**				
Pain Medications: Advil:_____ Motrin:_____ Naproxen (can be sold as "Naprosyn"):_____ Aleve:_____ Tylenol (acetaminophen) Actron:_____ Indocin (indomethacin):____ Migraine medications (e.g., Imitrex):_____ **Other:**				

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Hormone Replacement Therapy: Prempro: _____ Premarin: _____ **Other:**				
Rifampin: _____				
Theophylline: _____				
Methotrexate: _____				
Diet Drugs or Diet Supplements: Phen-Fen:_____ **Other:**				
Herbal Remedies or Supplements: Kava:_____ Ginseng:_____ Ginko Biloba:_____ St. John's Wort:_____ Sal Palmetto:_____ **Other:**				

Psychiatric Medications ***(Only answer these questions if you are claiming damages for mental or emotional distress. If you are not claiming such damages, please go the next question below.)***

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Antidepressants: Tricyclic Anti-Depressants (TCAs): Amitril:_____ Asendin:_____ Anafranil:_____ Adapin:_____ Ludiomil:_____ Vivactil:_____ Surmontil:_____ Elavil:_____ Endep:_____ Norpramin:_____ Pertofrane:_____ Imipramine:_____ Janimine:_____ Tofranil:_____ Aventyl:_____ Pamelor:_____ **Other:** Selective Serotonin Reuptake Inhibitors (SSRIs): Prozac:_____ Paxil:_____ Zoloft:_____ Celexa:_____ Luvox:_____ **Other:** Monamine Oxidase Inhibitors (MAOIs): Nardil:_____ Parnate:_____ **Other:**				Depression:_____ Chronic fatigue syndrome:_____ Bipolar disorder:_____ Generalized anxiety disorder:_____ Panic disorder:_____ Poor concentration:_____ Suicidal thoughts or attempts:_____ Alcohol or drug abuse:_____ Personality disorders:_____ Schizophrenia:_____ Eating disorders:_____ **Other:**

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Anti-Anxiety Medications: Benzodiazepines: Xanax:_____ Librium:_____ Klonopin:_____ Tranxene:_____ Valium:_____ Dalmame:_____ Paxipam:_____ Ativan:_____ Serex:_____ Centrax:_____ **Other:**				Depression:_____ Chronic fatigue syndrome:_____ Bipolar disorder:_____ Generalized anxiety disorder:_____ Panic disorder:_____ Poor concentration:_____ Suicidal thoughts or attempts:_____ Personality disorders:_____ Alcohol or drug abuse:_____ Schizophrenia:_____ Eating disorders:_____ **Other:**
Anti-Psychotic Medications: Haldol:_____ Risperdal:_____ Zyprexa:_____ Clozaril:_____ Leponex:_____ Geodon:_____ **Other:**				Schizophrenia:_____ **Other:**
Anti-Convulsant Medications: Tegretol:_____ Depakote:_____ **Other:**				Schizophrenia:_____ Seizure disorder:_____ **Other:**
Lithium:_____				Bipolar disorder:_____ **Other:**

2. List each any other prescription medicine not identified in Section VI (D) (1) you have taken regularly in the last ten (10) years, identifying the medication and the condition for which it was prescribed.

_____
Medication

_____
Condition for which prescribed

_____
Medication

_____
Condition for which prescribed

_____
Medication

_____
Condition for which prescribed

_____
Medication

_____
Condition for which prescribed

E. Smoking/Tobacco Use History: (*Check the answer and fill in the blanks applicable to your history of smoking and/or tobacco use.)*

___ Current smoker of cigarettes ___; cigars ___; pipe tobacco ___; or user of chewing tobacco/snuff ___.

1. Amount smoked or used: on average ____ per day for ____ years.

___ Past smoker of cigarettes ___; cigars ___; pipe tobacco ___; or user of chewing tobacco/snuff ___.

2. Date on which smoking/tobacco use ceased: _____
3. Amount smoked or used on average ____ per day for ____ years.

___ Never smoked cigarettes, cigars, pipe tobacco, or used chewing tobacco/snuff.

F. Drinking History:

1. Do you now drink or have you in the past drank alcohol (beer, wine, whiskey, etc.)?
   Yes ____ No ____

   If "no," go Section G below.

If "yes," check the following box which represents your greatest alcohol consumption over an extended (6 months or greater) period within the last 10 years:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe) _____

Check the following box which represents your weekly alcohol consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe) _____

G. Caffeine History:

1. Do you now or have you in the past consumed caffeinated beverages (coffee, tea, sodas, etc.)?
   Yes ____ No ____

   If "yes," check the following box which represents your greatest caffeine consumption over an extended (6 months or greater) period within the last 10 years:

   _____ 1-5 drinks per week
   _____ 6-10 drinks per week
   _____ 11-14 drinks per week
   _____ 15 or more drinks per week
   _____ Other (describe) _____

   Check the following box which represents your weekly caffeine consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

   _____ 1-5 drinks per week
   _____ 6-10 drinks per week
   _____ 11-14 drinks per week
   _____ 15 or more drinks per week
   _____ Other (describe) _____

H. Illicit Drugs:

1. Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you first experienced any alleged Vioxx-related injury? Yes ____ No ____

   If "yes," identify each substance and state when you first and last used it.

   _____
   _____
   _____

I. To the best of your knowledge, have you or your parents, grandparents, children or siblings ever experienced, or been told by a doctor or other healthcare professional, that you/they have, may have or had any of the following (check all that apply)?

_____ Abdominal aortic aneurysm (AAA disease)
_____ Alcoholism (as to you only, if applicable)
_____ Allergic reaction to medication
_____ Amputations (as to you only, if applicable)
_____ Aneurysm
_____ Atherosclerosis (blocked or narrow arteries)
_____ Atrial fibrillation
_____ Bipolar Disorder (as to you only, if applicable)
_____ Bleeding/clotting disorders (hemophillia, Von Willibrands disease, scurvy, other)
_____ Blood in stool or dark/black stools
_____ Cancer (lung, colon, liver, breast, other)
_____ Carotid stenosis (neck arteries)
_____ Chest pain/angina (at rest or with exertion)
_____ Chronic Fatigue Syndrome
_____ Chronic obstructive pulmonary disease/COPD
_____ Congenital heart disease
_____ Congestive heart failure
_____ Cor pulmonale
_____ Coronary heart disease
_____ Deep vein thrombosis/DVT/blood clot in lower legs
_____ Dermatomyositis
_____ Diabetes
_____ Eating disorders (anorexia, bulimia) (as to you only, if applicable)
_____ Endocarditis
_____ Esophagus problems (strictures, achalasia, Barrett's esophagus, difficulty swallowing, other)
_____ Eye hemorrhages
_____ Fibromyalgia
_____ Glaucoma
_____ Gout
_____ Heart attack/MI/myocardial infarction
_____ Heart murmur

_____ Heart valve problems (pulmonary hypertension, mitral valve prolapse, aortic/mitral valve regurgitation, aortic/mitral stenosis, bicuspid aortic valve, other)
_____ Heartburn/ reflux/ esophageal reflux disease/ GERD
_____ Hernia (strangulated or incarcerated)
_____ Herpes (as to you only, if applicable)
_____ High blood pressure/hypertension
_____ High total cholesterol, high LDLs (bad cholesterol), or low HDLs (good cholesterol)
_____ High triglycerides
_____ HIV/AIDS (as to you only, if applicable)
_____ Hodgkins disease/ non-Hodgkin's lymphoma
_____ Hypoxia (low oxygen saturation)
_____ Intestinal obstruction (not including constipation)
_____ Irregular heart rhythm (palpitations, tachycardia, bradycardia, atrial fibrillation, skipped beats, other)
_____ Kidney disease
_____ Leukemia
_____ Liver disease (hepatitis B/C, cirrhosis, cysts, other)
_____ Lupus
_____ Obesity (as to you only, if applicable)
_____ Osteoarthritis
_____ Pancreatitis
_____ Panic Disorder
_____ Peptic ulcer disease
_____ Peripheral vascular disease
_____ Pulmonary embolism/blood clot in the lung
_____ Rheumatic fever (as to you only, if applicable)
_____ Rheumatoid arthritis
_____ Seizure disorder
_____ Shortness of breath not associated with vigorous exercise
_____ Sickle cell anemia/ sickle cell trait
_____ Silent MI
_____ Sleep apnea
_____ Stomach problems (ulcers, perforations, bleeding)
_____ Stroke
_____ Swelling/edema/fluid in legs ankles (other than in pregnancy)
_____ Syphilis (as to you only, if applicable)
_____ Thyroid disorder and/or goiter
_____ Transient ischemic attack/TIA
_____ Tuberculosis

J. ***If you responded "yes" to any of the above***, please identify/state the condition, the individual affected, the date of onset (as to you only, if applicable), any medication prescribed to treat the condition (as to you only if applicable), and the name of the physician or other person who made the diagnosis or informed the individual of the condition and their address if not provided in the accompanying list (as to you only, if applicable).

1. Condition: _____

   Patient name: _____

   Onset date and medication: _____

   Name and address of physician or other person: _____

   _____

2. Condition: _____

   Patient name: _____

   Onset date and medication: _____

   Name and address of physician or other person: _____

   _____

3. Condition: _____

   Patient name: _____

   Onset date and medication: _____

   Name and address of physician or other person: _____

   _____

4. Condition: _____

   Patient name: _____

   Onset date and medication: _____

   Name and address of physician or other person: _____

   _____

5. Condition: _____

   Patient name: _____

   Onset date and medication: _____

   Name and address of physician or other person: _____

   _____

6. Condition: _____

   Patient name: _____

   Onset date and medication: _____

   Name and address of physician or other person: _____

   _____

K. Please indicate whether you have ever received any of the following treatments or diagnostic procedures:

   1. Surgeries (other than abortion), including but not limited to the following, and specify for what condition the surgery was performed: open heart or bypass surgery, pacemaker implantation, vascular surgery, IVC filter placement, carotid (neck artery) surgery, lung resection, or intestinal surgery.

Surgery	Condition	When Performed	Treating Physician	Hospital

2. Treatments/interventions for heart attack, angina (chest pain), or lung ailments, including but not limited to the following: cardiac catheterization, angioplasty (balloon), stenting, and electroconversion.

Treatment/ Intervention	Condition	When	Treating Physician	Hospital

3. Have you had any of the following tests performed: chest X-ray, CT scan, MRI, angiogram, EKG, echocardiogram, TEE (trans-esophageal echo), bleeding scan, endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head or neck, CT scan of the head, echocardiogram, bubble/microbubble study, EKG, Holter monitor.

   If "yes," answer the following:

Diagnostic Test	Condition	When	Treating Physician	Hospital

L. Have you ever participated in any clinical trials or studies relating to any drugs or treatments for any medical conditions? Yes ____ No ____

If "yes," please identify:

1. Name of the trial or study: _____

2. Sponsor of trial or study: _____

3. Drug or treatment studied: _____

4. Purpose of the drug or treatment studied: _____

5. Name and address of the investigator in charge of your care and treatment in the trial or study: _____
_____

6. The dates you participated in the trial or study: _____

VII. WAGE LOSS INFORMATION AND OTHER MONETARY LOSS CLAIMS

A. Are you making a claim for loss of wages? Yes ____ No _____

If "no," then go to Section VII (B).

1. State the total amount of time you have lost from work as a result of any condition that you claim or believe was caused by your use of Vioxx and the amount of income that you claim you lost. _____
_____

2. State your total earned income (including salary, bonus, and benefits) for each of the last ten (10) years.

Year	Income
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

_____ $_____

_____ $_____

_____ $_____

B. Have you paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Vioxx and for which you seek recovery in the action you have filed?

Yes ____ No ____

If "yes," state the total amount of such expenses at this time: $ _____

C. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Vioxx and for which you seek recovery in the action you have filed?

Yes ____ No ____

If "yes," state the total amount of such expenses at this time: $ _____

D. Please provide an itemized statement of the nature and amount of damages you are claiming. _____
_____
_____
_____

E. Please identify all persons not identified elsewhere in this ASPPF who you believe possess information relevant to your claims in this matter and for each, state his or her name, address, telephone number and a description of the information you believe he or she possesses.
_____
_____
_____
_____

VIII. PERSONAL INFORMATION OF LOSS OF CONSORTIUM

If you are a representative or loss of consortium plaintiff, please provide your personal responses to these questions.

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

B. Any other names used or by which you have been known, including but not limited to maiden name: _____

C. Social Security Number: _____

D. Driver's license number: _____ State issuing your license: _____

E. Date and place of birth: _____

F. Sex: Male ____ Female ____

G. Current street address and date began residing at this address: _____

_____

_____

City State Zip Code

H. Identify each other address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

Address	**Dates of Residence**	
	From:	**To:**

I. Identify each high school, college, university or other educational institution (except grade school) you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

Institution	Dates Attended	Course of Study	Diplomas & Degrees

J. Employment Information.

Current employer (if not currently employed, last employer):

_____
Name

_____
Address

_____
Dates of employment

_____
Occupation/Job duties

K. Date and place of marriage: _____

L. Have you ever been convicted or plead guilty of a crime? Yes ____ No ____

If "yes," where, when, and the crime: _____
_____

IX. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF OR CLAIMANT, AS THE CASE MAY BE, IS REQUIRED TO PRODUCE ALL MEDICAL RECORDS FROM ALL HEALTHCARE PROVIDERS WHOSE IDENTITY IS REQUESTED BELOW PURSUANT TO (a) PTO 28, SECTION II(A)(6), REGARDLESS OF WHETHER PLAINTIFF OR CLAIMANT IS REQUIRED TO RESPOND TO THIS AMENDED AND SUPPLEMENTAL PROFILE FORM UNDER SECTION II(A)(3), AND (b) PTO 29, SECTION II(A)(2).

List the following:

A. Your current family and/or primary care physician:

Name	Address	Approximate Dates of Treatment	
		From:	To:

B. To the best of your ability, identify each of your *other* family and/or primary care physicians from 1995 to the present.

Name	Address	Approximate Dates of Treatment	
		From:	To:

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient from 1995 to the present.

Name	Address	Admission Dates	Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) from 1995 to the present.

Name	Address	Treatment Dates	Reason for Treatment

E. Each physician or healthcare provider, not already listed in Sections IX (A) and IX (B) above, from whom you have received treatment from 1995 to the present.

Name	Address	Specialty	Approximate Dates of Treatment	
			From:	To:

F. Each pharmacy that has dispensed medication to you from 1995 to the present.

Name	Address	Approximate Dates Pharmacy Used	
		From:	To:

X. DOCUMENTS AND THINGS

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers by checking ***"yes"*** or ***"no."*** Where you have indicated ***"yes,"*** please attach the documents and things to your responses to this fact sheet. If not attached, please indicate why not.

A. A copy of all prescriptions for Vioxx, receipts, physician or office records, drug containers, packaging and other records that show the period during which you have taken Vioxx, the dosage of Vioxx and the frequency with which you took Vioxx.
Yes ____ No ____

B. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.
Yes ____ No ____

C. All diagnostic tests or test results for any disease, illness or conditions as detailed in this PPF.
Yes ____ No ____

D. Copies of all documents from physicians or other healthcare providers identified in this PPF.
Yes ____ No ____

E. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed or provided to you when your prescriptions for Vioxx were filled.
Yes ____ No ____

F. Copies of all advertisements or promotions for Vioxx received or seen before filing this action.
Yes ____ No ____

G. Executed authorizations signed and undated in the forms appended hereto, in following manner:

- If you are claiming damages for lost earnings or earning capacity, execute authorization forms #s 1-5 as provided on the court's website at http://vioxx.laed.uscourts.gov/Forms/Forms.htm
- If you are not claiming damages for lost earnings or earning capacity, execute authorization forms #s 1-3 and #5 as provided on the court's website at http://vioxx.laed.uscourts.gov/Forms/Forms.htm

H. If you claim you have suffered loss of earnings or earning capacity, all documents that evidence your income/earnings for each of the last ten (10) years.
Yes ____ No ____

I. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider and statements and explanations of benefits from your health care insurer or plan.
Yes ____ No ____

J. Copy of all written communications, whether written or electronic (including email, communications as part of internet "chat rooms" or e-mail groups), with others not including your counsel, regarding Vioxx, your injuries or this case.
Yes ____ No ____

K. Copies of letters testamentary, letters of administration, powers of attorney, guardianship or guardian *ad litem* orders or other documents relating to your status as plaintiff if you are suing and/or are completing this PPF and the Authorizations on behalf of another individual.
Yes ____ No ____

L. Decedent's death certificate (in death case).
Yes ____ No ____

M. Report of autopsy of decedent (in death case).
Yes ____ No ____

N. All photographs, drawings, slides, movies, day-in-the-life films, or videotapes, edited and unedited, taken by anyone, in your possession, the possession of your attorney or experts, or any other person acting on your behalf, relating to plaintiff's injuries, limitations or damages, and which are not privileged work product or otherwise not discoverable.
Yes ____ No ____

O. All documents relating to Vioxx in plaintiff's possession or control that were generated, published or disseminated by or obtained from Merck, whether or not it originated at Merck, that were in plaintiff's possession prior to the date on which plaintiff filed his/her Complaint in this action.
Yes ____ No ____

P. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, discussing alleged risks of Vioxx or any other COX-2 inhibitor drugs, or any alleged health impact, including, but not limited to, newspaper articles, scientific studies, health and fitness publications, union or other organizational newsletters, bulletins, or brochures.
Yes ____ No ____

Q. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, concerning any guidelines, procedures, requirements, recommendations, protocols, instructions, warnings or precautions for the use of Vioxx or any other COX-2 inhibitor drugs.
Yes ____ No ____

R. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, relating to any support or information group,

including internet sources, concerning Vioxx or any other COX-2 inhibitor drugs, including, but not limited to, communications from you, or received by you from such groups concerning Vioxx or other COX-2 inhibitor drugs.
Yes ____ No ____

S. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, concerning Vioxx or any other COX-2 inhibitor drugs distributed by public or private organizations, including without limitation, the American Nursing Association, the Food and Drug Administration, the Center for Disease Control, the American Medical Association, the American Heart Association, the National Institutes of Health, the Occupational Safety and Health Administration, or NIOSH.
Yes ____ No ____

T. Any videotape or sound recordings that have been broadcast on television or radio, or any newspaper, magazine or other published document wherein plaintiff has discussed Vioxx or any aspect of the alleged incident or injury that forms the basis of this action.
Yes ____ No ____

U. Any and all product insert data sheets, marketing materials, promotional materials, advertisements, packaging information, labels, bottles, boxes, samples, labeling fact sheets or informational sheets provided to plaintiff by any prescribing physician, pharmacy or other healthcare provider, or any other materials provided by any prescribing physician, pharmacy, or other healthcare provider, or anyone else prior to the date on which plaintiff filed his/her Complaint in this action, and relating to Vioxx, CELEBREX®, or BEXTRA®.
Yes ____ No ____

V. Each and every document in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, including but not limited to magazine or newspaper articles, brochures, material from internet sites, videotapes (including videotapes of news or other television programs), or audiotapes (including tapes of news or other radio or television programs), that mentions, refers to or relates to Vioxx and that was made available to plaintiff or reviewed by plaintiff prior to ingesting Vioxx.
Yes ____ No ____

W. All non-privileged documents reflecting communications between plaintiff and any other person or entity, prior to the date on which plaintiff filed his/her Complaint in this action, and relating to, referring to, or regarding the allegations of the Complaint, Merck, Vioxx or any injury you claim resulted from plaintiff's use of, or exposure to, Vioxx.
Yes ____ No ____

X. Each and every document that evidences any communication between plaintiff and any doctor, any employer, any defendant, any federal or state agency, or any other person (other than your attorney) regarding the incident made the basis of this suit or your claims in this lawsuit.
Yes ____ No ____

Y. All entries in personal diaries, calendars, journals, logs, appointment books, date books, or similar materials plaintiff kept or continues to keep from January 1, 1995 to the present which relate or refer to plaintiff's medical care, medical condition, or employment and not prepared at the direction of your attorney.
Yes ____ No ____

Z. Have you prepared personal diaries, calendars, journals, logs, appointment books, date books, or similar materials at the direction of your attorney(s)?
Yes ____ No ____

ADDITIONAL INFORMATION

ADDITIONAL INFORMATION

CERTIFICATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Profile Form is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part X of this declaration, to the extent that such documents are in my possession, custody, control or access, or in the possession, custody, control or access of my lawyers, and that I have supplied the authorizations attached to this declaration.

_____	_____	_____
Signature	Print Name	Date

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION	MDL No. 1657 **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)**

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing medical records regarding the above-named person's medical care, treatment, physical condition, and/or medical expenses to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments,

medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation and may no longer be protected by HIPAA. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION

MDL No. 1657

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL/PSYCHIATRIC RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing records regarding the above-named person's psychological or psychiatric care, treatment, condition, and/or expenses to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that this authorization includes information regarding the diagnosis and treatment of psychiatric and psychological disorders, and that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, psychiatric treatment and counseling records, psychological treatment and counseling records, narratives, and any correspondence/memoranda and billing

information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation and may no longer be protected by HIPAA. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf: _____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCT LIABILITY LITIGATION

MDL No. 1657

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing psychotherapy notes regarding the above-named person's medical care, treatment, physical/mental condition, and/or medical expenses to law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that this authorization includes all psychotherapy notes maintained separately from the above-named person's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.

I understand that the health information being disclosed by these psychotherapy notes may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this

authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation and may no longer be protected by HIPAA. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION	MDL No. 1657 **AUTHORIZATION FOR RELEASE OF RECORDS (To be signed by plaintiffs making a claim for lost wages, earnings or earning capacity.)**

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing records and information in its possession regarding the above-named person's employment, income and education to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes.

I understand that this authorization includes the above-named person's complete employment personnel file (including attendance reports, performance reports, W-4 forms, W-2 forms, medical reports, workers' compensation claims), and also includes all other records relating to employment, past and present, all records related to claims for disability, and all educational records (including those relating to courses taken, degrees obtained, and attendance records). This listing is not meant to be exclusive.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION	Case No. 1657 **AUTHORIZATION FOR RELEASE OF RECORDS (To be signed by plaintiffs *not* making a claim for lost wages or earnings or earning capacity.)**

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing records and information in its possession regarding the above-named person's employment and education (with the exception of W-4 and W-2 forms) to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes.

I understand that this authorization includes the above-named person's complete employment personnel file with the exception of W-4 and W-2 forms (including attendance reports, performance reports, medical reports, workers' compensation claims), and also includes all other records relating to employment, past and present, all records related to claims for disability, and all educational records (including those relating to courses taken, degrees obtained, and attendance records). This listing is not meant to be exclusive.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____