UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In Re: Oil Spill by the Oil Rig "Deepwater Horizon" in the Gulf of Mexico, on April 20, 2010	*	**MDL No. 2179**
	*	**SECTION: J**
	*	**JUDGE BARBIER**
This Document Relates to: *No. 12-968: BELO*	*	**MAG. JUDGE WILKINSON**

ORDER

Before the Court is the BP Parties' Motion to Modify BELO Cases Initial Proceedings Case Management Order (Rec. Doc. 24109), which requests that certain forms currently found in Exhibit B to the BELO Cases Initial Proceedings Case Management Order (Rec. Doc. 14099-2) be replaced with revised versions. BP represents that Class Liaison Counsel does not object these amendments. The Court has reviewed the motion and finds it should be granted. Accordingly,

IT IS ORDERED that the Motion to Modify BELO Cases Initial Proceedings Case Management Order (Rec. Doc. 24109) is GRANTED.

IT IS FURTHER ORDERED that Exhibit B to the BELO Cases Initial Proceedings Case Management Order (Rec. Doc. 14099-2) is replaced and superseded by the revised version of "Exhibit B" which is attached to this Order.

IT IS FURTHER ORDERED that the Clerk of Court hereafter shall include the revised version of "Exhibit B" attached to this Order in place of the former version of Exhibit B when filing a copy of the BELO Cases Initial Proceedings Case Management Order into the docket of an individual BELO case as required under § VI(2) of the BELO Cases Initial Proceedings Case Management Order.

IT IS FURTHER ORDERED that the Claims Administrator hereafter shall include the revised version of "Exhibit B" attached to this Order in place of the former version of Exhibit B when providing a copy of the BELO Cases Initial Proceedings Case Management Order to a BELO claimant as required under § VI(1) of the BELO Cases Initial Proceedings Case Management Order.

New Orleans, Louisiana, this 16th day of March, 2018.

United States District Judge

EXHIBIT B TO
BELO CASES INITIAL PROCEEDINGS
CASE MANAGEMENT ORDER

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

***	CIVIL ACTION
VERSUS	NO.
BP EXPLORATION & PRODUCTION, INC. AND BP AMERICA PRODUCTION COMPANY	JUDGE BARBIER MAG. JUDGE WILKINSON

Related to: 12-968 BELO
in MDL No. 2179

PLAINTIFF PROFILE FORM

PLAINTIFF'S FULL NAME: _____

Please answer every question to the best of your knowledge. You are signing and submitting this Plaintiff Profile Form under penalty of perjury and must provide information that is true and accurate. If you cannot recall all of the details requested, please provide as much information as you can. For each question where the space provided does not allow for a complete answer, please attach as many additional sheets of paper as necessary to fully answer the question.

If you are asked to identify a person (such as doctors or witnesses), give the name and last-known address and telephone number.

NOTE: Please provide information regarding the person who claims injury. The terms "you" and "your" refer only to that person, not to the individual who may be completing this form in a representative capacity (except Nos. 12-18). If the person who claims injury is deceased, the personal representative should respond as of the time immediately prior to his or her death unless a different time period is specified.

YOUR BACKGROUND INFORMATION

1. Current address: _____

_____

_____

Initial _____

2. Telephone number: _____

3. Maiden or other names used or by which you have been known, and the dates during which you were known by such names: _____

4. Date and Place of Birth: _____

5. Male _____ Female _____

6. Social Security Number: _____

7. Each address (other than your current address) at which you have lived during the last ten (10) years, and list the dates of residence for each one:

Address	**Dates of Residence**

8. Driver's License Number and State Issuing License: _____

A. Have you ever had your driving privileges suspended or limited based on your health or physical condition? Yes _____ No _____

B. If so, when and for what reason(s)? _____

_____

_____

Initial _____

9. Employment Information:

A. Current employer (if not employed, last employer):

Employer	Address	Dates of Employment	Occupation/Job Duties

B. Past employers (last ten (10) years):

Employer	Address	Dates of Employment	Occupation/Job Duties

10. Have you ever been out of work for more than thirty (30) days for reasons related to your health (other than pregnancy)? Yes ____ No _____ If "*Yes*," when were you out of

Initial _____

work and why? _____

_____

11. If you are represented by counsel, please provide the following information:

Plaintiff's primary attorney:_____

Law Firm:_____

Address: _____

_____

Telephone number: _____ Fax number: _____

E-mail address: _____

INFORMATION ABOUT THE PERSONAL REPRESENTATIVE

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

12. Name: _____

13. Address:_____

_____

14. In what capacity are you representing the individual or estate? _____

_____

15. What is your relationship to the person claiming to be injured? _____

_____

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

Court, Court Term, & Case Number: _____

_____

Initial _____

17. Date of Appointment:_____

18. If you represent the estate, when and where did the decedent die? _____

_____

_____

INFORMATION ABOUT THE CLAIM

19. Are you claiming that you have developed or may develop bodily injury as a result of exposure to the oil spill and/or chemical dispersant used in response to the oil spill?

Yes ____ No ____

20. Describe in as much detail as possible the bodily injury (or medical condition) you claim resulted from your exposure to the oil spill and/or chemical dispersant?

_____

_____

_____

21. Describe in as much detail as possible the circumstance(s) in which your exposure to the oil spill and/or chemical dispersant occurred: _____

_____

_____

_____

A. Where did the exposure(s) occur? _____

B. When did the exposure(s) occur? _____

C. To what substance or chemical were you exposed, if you know? _____

_____

D. For how long were you exposed to this substance or chemical? _____

_____

Initial _____

22. Who witnessed your exposure to this substance or chemical? _____

_____

_____

23. During your alleged exposure, were you provided by BP or any other entity protective clothing, gear, equipment, etc.? Yes ____ No ____

A. Identify the specific clothing, gear, equipment, etc. you were provided: _____

_____

B. When and how often were you provided such clothing, gear, and equipment? ____

_____

_____

C. Where or from whom were you provided the clothing, gear, equipment, etc.?

_____

_____

24. During your alleged exposure, did you wear and/or use protective clothing, gear, equipment, etc.? Yes ____ No ____ If "*Yes*,"

A. Identify the specific clothing, gear, equipment, etc. worn and/or used: _____

_____

B. When and how often did you use and/or wear such clothing, gear, and equipment?

_____

_____

_____

C. Where or from whom did you obtain the clothing, gear, equipment, etc.?

_____

_____

Initial _____

D. If you did not use the clothing, gear, equipment provided to you, please explain why: _____

_____

_____

25. Name of doctor(s) (or other healthcare providers) who diagnosed your injury (or condition)? _____

_____

_____

_____

A. For each doctor (or other healthcare provider) identified in the prior question, when did he/she make the diagnosis? _____

_____

_____

_____

B. Have you had any discussion with physician(s) or other healthcare provider(s) about whether your alleged injury or injuries are, or might be, related to exposure to the substance or chemical listed in answering Question 21(C)?

Yes ____ No ____

If "*Yes*," please provide the following information:

Name & Address of Healthcare Provider	**Date of Discussion**	**What Was Said**

26. Who else (beside your doctor or healthcare providers) knows about your injury (or condition)? _____

Initial _____

_____

_____

_____

27. Does the alleged injury, or do the alleged injuries, persist today?
Yes ____ No ____ If "*Yes*,"

A. Do you still receive treatment? Yes _____ No _____

B. If so, from whom? _____

28. Have you ever suffered this type of injury or condition before (i.e., before the date given in your answer to Question 21(B))? Yes _____ No _____. If "*Yes*,"

A. When? _____

B. Who diagnosed the injury (or condition) at that time? _____

_____

_____

C. Who treated the injury (or condition) at that time? _____

29. Do you claim that your exposure to the oil spill and/or chemical dispersant worsened an injury (or condition) that you already had or had in part?
Yes ___ No ____. If "*Yes*,"

A. What injury (or condition) was made worse? _____

_____

_____

30. Are you claiming a mental and/or emotional condition as a consequence of exposure to the oil spill and/or chemical dispersant? Yes _____ No _____ If "*Yes*,"

Initial _____

A. Identify each healthcare provider (including but not limited to primary care physicians, psychiatrists, psychologists, counselors) from whom *you have s*ought treatment for psychological, psychiatric, or emotional condition during the last ten (10) years: _____

_____

_____

_____

_____

_____

_____

_____

B. Describe the condition for which you received consultation/treatment: _____

_____

_____

C. Dates of consultation/treatment: _____

D. Medications and other treatments prescribed or recommended by the provider:

_____

_____

_____

31. Identify all persons who possess information concerning your injury and/or your medical conditions. (Please attach additional sheets as necessary.)

A. Name: _____

Address: _____

Relationship: _____

What do they know about your injury or condition? _____

_____

Initial _____

B. Name: _____

Address: _____

Relationship: _____

What do they know about your injury or condition? _____

_____

C. Name: _____

Address: _____

Relationship: _____

What do they know about your injury or condition? _____

_____

32. Do you claim or expect to claim that you lost earnings or suffered impairment of earning capacity as a result of any physical, mental, or emotion injury that you allege?

Yes ____ No ____ If "*Yes*,"

A. What was your annual income at the time you were injured? _____

_____

B. How long do you claim that you were unable to work due to the claimed injury or had impaired capacity (please provide dates)? _____

_____

C. How much do you claim in lost wages? _____

_____

INSURANCE AND OTHER COMPENSATION INFORMATION

33. Have you filed a worker's compensation claim in the past 10 years?

Yes ____ No ____ If "*Yes*," please state:

A. Year claim was filed: _____

Initial _____

B. Where claim was filed: _____

C. Claim number, if applicable: _____

D. Nature of the injury (or condition): _____

_____

E. Period of disability: _____

F. If your claim for compensation has been approved, please describe the amount of compensation received or to be received. _____

(Please copy and attach additional pages if necessary to provide a complete response.)

34. Have you made a social security disability claim in the past ten years?

Yes: ____ No: ____ If "*Yes*," please state:

A. Year claim was filed: _____

B. Where claim was filed: _____

C. Claim number, if applicable: _____

D. Nature of the injury (or condition): _____

_____

E. Period of disability: _____

F. State whether your claim for compensation has been approved or denied: _____

G. If your claim for compensation has been approved, please describe the amount of compensation received or to be received._____

_____

(Please copy and attach additional pages if necessary to describe more than one claim.)

35. Have you made any other form of disability claim in the past 10 years?

Yes: ____ No: ____ If "*Yes*," please state:

A. When was the claim filed? _____

Initial _____

B. With whom was the claim filed? _____

_____

C. What was the nature of the disability? _____

_____

_____

D. For how long were you disabled? _____

E. State whether your claim for compensation has been approved or denied. _____

_____

F. If your claim for compensation has been approved, please describe the amount of compensation received or to be received. _____

_____

(Please copy and attach additional pages if necessary to describe more than one claim.)

36. Have you made a claim for compensation for your claimed injuries with any insurance company, Medicare, or any other party that may be responsible for providing you with compensation in the past 10 years? Yes: _____ No: _____ If "*Yes*," please state:

A. Year claim was filed: _____

B. Where claim was filed: _____

C. Claim number, if applicable: _____

D. Nature of the injury (or condition): _____

E. Period of disability: _____

F. State whether your claim for compensation has been approved or denied: _____

G. If your claim for compensation has been approved, please describe the amount of compensation received or to be received. _____

_____

Initial _____

(Please copy and attach additional pages if necessary to provide a complete response.)

37. Have you ever filed a lawsuit or made a claim alleging personal injury, *other than* the present lawsuit? Yes: _____ No: _____ If "*Yes*,"

A. When did you file the lawsuit? _____

B. Who were the parties? _____

_____

_____

C. What was the case/civil action/docket number? _____

_____

D. What claim did you make? _____

_____

E. Describe the result of the lawsuit, including the amount of any compensation that you received. _____

_____

38. Have you ever filed a lawsuit or made a claim, *other than* the present lawsuit, seeking damages for the injuries you claim in this case? Yes: _____ No: _____ If "*Yes*,"

A. When did you file the lawsuit or claim? _____

B. If you filed a lawsuit:

i. Who were the parties? _____

_____

ii. What was the case/civil action/docket number? _____

iii. What claim did you make? _____

_____

Initial _____

iv. Describe the result of the lawsuit, including the amount of any compensation that you received. _____

_____

C. If you filed a claim that was not a lawsuit, please describe the circumstances of that claim and the result: _____

_____

_____

YOUR MEDICAL HISTORY

39. Have you ever been exposed to substances or sources of contaminants and/or toxins other than the ones alleged in this lawsuit? Yes ___ No ____ If "*Yes*,"

A. Describe in as much detail as possible the circumstances in which your exposure to such substances or sources occurred: _____

_____

_____

_____

i. Where did the exposure(s) occur?

ii. When did the exposure(s) occur?

iii. To what contaminant and/or toxins were you exposed?

iv. What was your level of exposure to each contaminant and/or toxin, if you know?

v. For how long were you exposed to each contaminant and/or toxin?

Initial _____

40. Smoking history. Check the answer and fill in the blank applicable to your history of smoking and/or tobacco use:

A. _____ Never smoked or chewed.

B. _____ Smoked in the past, but stopped

i. When did you start?_____

ii. When did you stop?_____

iii. What did you use? Cigarettes/cigars/pipe tobacco/chewing tobacco/snuff.

_____

iv. Amount you smoked or chewed: on average ___ per day for ___ years.

C. _____ Smoke now

i. When did you start?_____

ii. When did you stop?_____

iii. What did you use? Cigarettes/cigars/pipe tobacco/chewing tobacco/snuff.

_____

iv. Amount you smoked or chewed: on average ___ per day for ___ years.

41. Have you ever experienced, been diagnosed with, or been treated for the following:

A. Health conditions, including but not limited to:

Anemia	Yes: _____	No: _____
Bacterial Infection	Yes: _____	No: _____
Diabetes	Yes: _____	No: _____
Obesity	Yes: _____	No: _____
Blood Disorder	Yes: _____	No: _____

Initial _____

Skin Disorder(s) (e.g. rashes, blisters)	Yes: _____	No: _____
Stroke	Yes: _____	No: _____
Seizures	Yes: _____	No: _____
Muscle Disorder	Yes: _____	No: _____
Paralysis	Yes: _____	No: _____
Severe Headaches or Migraines	Yes: _____	No: _____
Cancer	Yes: _____	No: _____
Allergies	Yes: _____	No: _____
Compromised Immune System	Yes: _____	No: _____
Severe Allergic Reaction	Yes: _____	No: _____
Cardiovascular Disease (including high blood pressure)	Yes: _____	No: _____
Heart Attack	Yes: _____	No: _____
Chest Pain	Yes: _____	No: _____
Kidney Disease	Yes: _____	No: _____
Liver Disease	Yes: _____	No: _____
Respiratory Illness(es)	Yes: _____	No: _____
Ocular (Eye) Condition(s)	Yes: _____	No: _____
Conditions affecting the ears and hearing (including tinnitus)	Yes: _____	No: _____
Conditions affecting the nose and sinuses (including rhinosinusitus)	Yes: _____	No: _____
Mental Health Issues	Yes: _____	No: _____

B. Alcohol: Number of drinks per day: _____

Number of drinks per week: _____

Initial _____

42. If you answered "*Yes*" to any of the above, for *each* condition:

A. When was it diagnosed? (identify condition and month/year)

B. Who diagnosed it? (identify condition and health care provider)

C. Who treated it? (identify condition and health care provider)

YOUR FAMILY INFORMATION

43. Have you ever been married? Yes _____ No _____ If "*Yes*," for each spouse, please identify:

A. Spouse's name: _____

B. Date of marriage: _____

C. Spouse's occupation: _____

44. Have any of your children, parents, siblings, or close relatives (aunts, uncles, or grandparents) suffered from any of the conditions listed in Question 40? If "*Yes*," identify each such person below and provide the information requested.

A. Name: _____

B. Relationship to Plaintiff: _____

C. Current Age (or Age at Death): _____

D. Type of Condition: _____

E. If Applicable, Cause of Death: _____

Initial _____

YOUR DOCTORS

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

Name	Address

46. Your primary care physicians for the past ten (10) years:

Name	Address

Initial _____

47. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the past ten (10) years:

Name	Address	Approximate Dates	Reason for Admission

48. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the last ten (10) years:

Name	Address	Approximate Dates	Reason for Treatment

Initial _____

49. Please list any and all surgeries, procedures, and hospitalizations that you have had in the past ten (10) years that you have not already described above.

Approximate Date	Reason for and Description of Procedure	Doctor Name and Address (including hospital or facility)

50. Please list any and all surgeries, procedures, and hospitalizations that you have had at any time that you have not already identified above for diseases or medical conditions similar to the injury you are alleging in this lawsuit:

Approximate Date	Reason for and Description of Procedure	Doctor Name and Address (including hospital or facility)

Initial _____

51. Each physician or healthcare provider not already identified above from whom you have received treatment in the last ten (10) years:

Name	Address	Approximate Dates	Reason for Admission

52. Each pharmacy that has dispensed medication to you in the past ten (10) years:

Name	Address

Initial _____

YOUR DOCUMENTS

53. 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.

A. Medical records. Yes ____ No ____.

B. Decedent's death certificate (if applicable). Yes ____ No ____.

C. Report of autopsy of decedent (if applicable). Yes ____ No ____.

54. Authorizations—Please sign and attach to this Fact Sheet the authorizations for the release of records appended hereto.

55. Documents in your possession—If you have any of the following materials in your custody or possession, or in the possession, custody or control of your lawyers, please attach a copy to this Fact Sheet, but only to the extent that production of such documents in the attorney's possession does not violate the work product doctrine or attorney client privilege.

A. 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.

B. Copies of all medical records, bills, and any other documents from physicians, healthcare providers, hospitals, pharmacies, insurance companies, or others who have provided treatment to you in the past ten (10) years or that you otherwise identified in this Fact Sheet.

C. All documents constituting, reporting, summarizing, or referring to any medical test, psychological test, psychiatric test, intelligence test, mental health test, or standardized test of any kind ever taken by or administered to plaintiff in the past ten (10) years.

Initial ____

D. All documents constituting, concerning, or relating to oil spill clean-up instructions, policies, and/or procedures; warnings regarding exposure; or other materials distributed with or provided to you in connection with your exposure to the oil spill.

E. Copies of photos of any protective gear, clothing, shoes, or equipment worn by you at any time during your exposure to the oil spill. (Plaintiffs must maintain the originals of the items requested in this subpart.)

F. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

G. All documents which mention or refer to any alleged health risks or hazards related to the oil spill and/or exposure thereto in your possession at or before the time of the injury alleged in your Complaint.

H. All journals, diaries, notes, letters, emails, social media entries/postings, or other documents written by you or received by you which refer to your health or well-being, including any injuries or illnesses, or which refer to the oil spill or the risks of exposure to the spill.

I. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the last five (5) years.

J. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other healthcare provider.

K. Copies of letters testamentary or letters of administration relating to your status as a plaintiff (if applicable).

L. Decedent's death certificate and autopsy report (if applicable).

Initial _____

M. Any release executed by you or another person authorized to act on your behalf in connection with the allegations that form the basis of your claim.

N. All documents that you submitted to the Deepwater Horizon Medical Benefits Claims Administrator (Garretson Resolution Group) concerning any claim for compensation.

Initial _____

VERIFICATION

I,_____, have reviewed the information provided in this Plaintiff's Profile Form, and I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information is true, complete, and correct to the best of my knowledge, information, and belief.

I have supplied all the documents requested in the Section entitled "Your Documents" in this Plaintiff's Profile Form, to the extent that such documents are in my possession or in the possession of my lawyers, and to the extent that production of such documents in the attorney's possession does not violate the work product doctrine or attorney client privilege.

I have signed and supplied the authorizations attached to this Verification.

I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respect incomplete or incorrect.

_____ _____

Signature Date

_____

Print Name

Initial _____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: Oil Spill by the Oil Rig "Deepwater Horizon" in the Gulf of Mexico, on April 20, 2010

Applies to: 12-cv-968: BELO

MDL No. 2179

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

Name:
Date of Birth:
Social Security No.:
Address:

TO: _____
Medical Provider

I, the individual named above, hereby authorize my health care provider(s), health plan(s), and health insurer(s) to disclose my health records to BP America and/or BP Exploration and Production and their designated agent ("Receiving Parties"), Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA, 70139. These records shall be used or disclosed solely in connection with the currently pending BELO litigation involving the person named above.

I hereby grant any reimbursement claim, lien holder or state or federal agency, and the contract representatives of either, permission to share with the Recipient all reimbursement claim and lien information and confirming health records regarding any conditional payments made, or medical care performed, by the claim / lien holder relating to the following condition(s):

_____

(collectively referred to as "lien information").

As referenced to above, my health records include any and all of the following:

Records of my medical condition(s), diagnoses, and treatment, including, but not limited to, physician's records; surgeons' records; discharge summaries; progress notes; consultations; pharmaceutical records; medication sheets; patient information sheets; consents for treatment; medical reports; x-rays and x-ray reports; CT scans; MRI films; photographs; and any other radiological, nuclear medicine, or radiation therapy films; interpretations of diagnostic tests; pathology materials, slides, tissues, and laboratory results and/or reports; consultations; physical therapy records; drug and alcohol abuse records; HIV/AIDS diagnosis and/or treatment; physicals and histories; correspondence; psychiatric records; psychological records; psychometric test results; social worker's records; other information pertaining to the physical and mental condition; all hospital summaries and hospital records including, but not limited to, admitting records; admitting histories and physicals; case records, discharge summaries; physician's orders, progress notes, and nurses' notes; medical record summaries; emergency room records; all other hospital documents and memoranda pertaining to any and all hospitalizations and/or out-patient visits; and

Any and all insurance records; statements of account, bills or billing records, or invoices; any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, or diagnosis pertaining to my health.

I understand 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, and treatment for alcohol and drug abuse.

I understand that this information will permit counsel in this case to communicate with my healthcare providers concerning the medical records disclosed pursuant to this authorization.

In the event that this facility or medical provider requires execution of a proprietary authorization for the release of medical records, I shall execute such authorization within 30 days of my attorneys or I receiving from the Receiving Parties or their designated agents the required form. Similarly, if the policies of this institution or medical provider require a more recently-dated execution of this authorization than the one provided, I shall re-execute this authorization within 30 days of the Receiving Parties alerting my attorneys or I of that fact.

I understand that I have the right to revoke this authorization at any time. I understand that if I wish to revoke the authorization, I must do so in writing and must provide my written revocation to any and all of my health care providers, health plans, or health insurers, state or federal agencies and all other third party lien holders to which the revocation will apply. I understand that the revocation will not apply to any disclosures that have already been made in reliance on this authorization prior to the date upon which the disclosing health care provider, health plan, health insurer, or such other third party receives my written revocation.

I understand that my authorization of the disclosure of my health record and lien information is voluntary and that I therefore can refuse to sign this authorization. I also understand that I do not need to sign this authorization to obtain health treatment or to receive or be eligible to receive benefits for coverage of health treatment.

I understand that, once disclosed to the Recipient, my health records and lien information may not be protected by federal privacy law and could be further disclosed to others without my authorization.

This authorization shall expire one (1) year from the date on which it was signed or upon final resolution of my BELO claim in the Medical Benefits Class Action Settlement in MDL 2179.

I have a right to receive and retain a copy of this authorization when signed below.

Name of PLAINTIFF [PRINT]	Signature	Date

OR

Name and title of AUTHORIZED REPRESENTATIVE authorized to act on behalf of PLAINTIFF [PRINT]	Signature	Date

Relationship to PLAINTIFF [PRINT]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: Oil Spill by the Oil Rig "Deepwater Horizon" in the Gulf of Mexico, on April 20, 2010

Applies to: 12-cv-968: BELO

MDL No. 2179

AUTHORIZATION FOR RELEASE OF RECORDS PROVIDED TO *DEEPWATER HORIZON* MEDICAL BENEFITS CLAIMS ADMINISTRATOR

Name: _____
Date of Birth: _____
Social Security No.: _____

I, the individual named above, hereby authorize the Deepwater Horizon MEDICAL BENEFITS CLAIMS ADMINISTRATOR ("CLAIMS ADMINISTRATOR") to release all data, documentation, and records pertaining to me in the possession, custody, or control of the CLAIMS ADMINISTRATOR to BP America and/or BP Exploration and Production and their designated agent ("Receiving Parties"), Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA, 70139. These records shall be used or disclosed solely in connection with the currently pending BELO litigation involving the person named above.

As referred to above, certified data, documentation, and records pertaining to me include any and all of the following: documents submitted to the CLAIMS ADMINISTRATOR relating to claims for compensation arising from a medical condition, illness, or injury allegedly caused by the DEEPWATER HORIZON INCIDENT; the following forms and all information and documents submitted as part of these forms and in support thereof: the Mediation Information form; medical and other health records; employment records; documents provided by my attorneys; and any and all other data, documentation, and records provided to the CLAIMS ADMINISTRATOR pertaining to me, and also including materials otherwise gathered or generated by GRG, including claim determination documents, payment documents, and releases executed by plaintiff.

This authorization shall expire one (1) year from the date on which it was signed or upon final resolution of my BELO claim in the Medical Benefits Class Action Settlement in MDL 2179.

_____
Name:

_____
Date

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: Oil Spill by the Oil Rig "Deepwater Horizon" in the Gulf of Mexico, on April 20, 2010

Applies to: 12-cv-968: BELO

MDL No. 2179

AUTHORIZATION FOR RELEASE OF EMPLOYMENT/PLAINTIFF RECORDS

Name:
Date of Birth:
Social Security No.:
Address:

TO: _____

I, the **EMPLOYEE** named above, do hereby **AUTHORIZE** AND **DIRECT** my past or current EMPLOYER identified above to disclose and release to BP America and/or BP Exploration and Production and their designated representative, Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA, 70139, any and all records, files, documents, and other information concerning my employment with the above-named **EMPLOYER**.

This authorization shall expire one (1) year from the date on which it was signed or upon a final resolution of my BELO claim in the MEDICAL BENEFITS CLASS ACTION SETTLEMENT in MDL 2179

_____	_____	_____
Name of EMPLOYEE [PRINT]	Signature	Date

OR

_____	_____	_____
Name and title of AUTHORIZED REPRESENTATIVE authorized to act on behalf of EMPLOYEE [PRINT]	Signature	Date

_____
Relationship to EMPLOYEE [PRINT]

Form **SSA-7050-F4** (10-2016) UF
Discontinue prior editions
Social Security Administration

OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information
Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings
Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are FREE to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, authorizes us to collect the information on this form. We will use the information you provide to identify your records and send the earnings information you request. Completion of this form is voluntary; however, failure to do so may prevent your request from being processed.

We rarely use the information in your earnings record for any purpose other than for determining your entitlement to Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

A complete list of routine uses for earnings information is available in our Systems of Records Notices entitled, the Earnings Recording and Self-Employment Income System (60-0059), the Master Beneficiary Record (60-0090), and the SSA-Initiated Personal Earnings and Benefit Estimate Statement (60-0224).
In addition, you may choose to pay for the earnings information you requested with a credit card.
31 C.F.R. Part 206 specifically authorizes us to collect credit card information. The information you provide about your credit card is voluntary. Providing payment information is only necessary if you are making payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order). If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and the Social Security Administration's (SSA) account.

Routine uses applicable to credit card information, include but are not limited to:
(1) to enable a third party or an agency to assist Social Security to effect a salary or an administrative offset or to an agent of SSA that is a consumer reporting agency for preparation of a commercial credit report in accordance with 31 U.S.C. §§ 3711, 3717 and 3718; and (2) to a consumer reporting agency or debt collection agent to aid in the collection of outstanding debts to the Federal Government.
A complete list of routine uses for credit card information is available in our System of Records Notice entitled, the Financial Transactions of SSA Accounting and Finance Offices (60-0231). The notice, additional information regarding this form, routine uses of information, and our programs and systems is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) - - One SSN per request

Date of Birth: / / Date of Death: / /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☐ **Itemized Statement of Earnings $115**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Year(s) Requested: to
Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $33.00 fee.

☐ **Certified Yearly Totals of Earnings $33**
(Does not include the names and addresses of employers)
Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name

Address State

City ZIP Code

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

Signature AND Printed Name of Individual or Legal Guardian

SSA must receive this form within 120 days from the date signed
Date / /

Relationship (if applicable, you must attach proof) Daytime Phone:

Address State

City ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for **only ONE** Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select **ONE** type of earnings statement and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings
This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings
This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attach the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings
The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings
You can request earnings information from the record of a deceased person if you are:
- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $115 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings
In most instances, individuals request Itemized Statements of Earnings for purposes unrelated to our programs such as a private pension plan or personal injury suit. Bulk submitters may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional $33.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings
We charge $33 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable. DO NOT SEND CASH.

You may pay by credit card, check or money order.
- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

- **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to:	If using private contractor such as FedEx mail form, supporting documentation and applicable fee to:
Social Security Administration Division of Earnings and Business Services P.O. Box 33011 Baltimore, Maryland 21290-3003	**Social Security Administration** Division of Earnings and Business Services 6100 Wabash Ave. Baltimore, Maryland 21215

- **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$115.00	$148.00

- **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $33.00. You may obtain non-certified yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	(☐☐☐) ☐☐☐ - ☐☐☐☐ Area Code
Credit Card Number	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $33, $115, or $148 SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov. **Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:** _____

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)