

**Authorization for Use and Disclosure of Protected Health Information
Pursuant to the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)***

To: Vioxx LRP Participating Private Health Care Plans and Recovery Contractors

Re: _____ (Name of Vioxx Claimant)

Purpose: This document will authorize the following person(s)/entity for purposes of resolving subrogation and/or reimbursement interests, if any, in my third-party claim. The entities and persons named below are authorized to request and receive from you any and all information related to this claim, and discuss, negotiate, and ultimately resolve this claim on my behalf.

Person(s)/Entity Authorized to Receive and Use Information:

The Garretson Firm Resolution Group, Inc., its agents, or any assigned agency possessing specialized knowledge needed in procuring judgment or settlement.

Mailing Address:

**The Garretson Firm Resolution Group, Inc.
PO Box 12540
Charlotte NC 28220**

I hereby give any lien holder and its contract representatives permission to share the information described below with The Garretson Firm Resolution Group, Inc., and its representatives. It is understood that The Garretson Firm Resolution Group, Inc and its representatives may re-disclose this information in their efforts to resolve your interest. Furthermore, it is understood that this health-related information will no longer be protected by the Federal privacy regulations. Therefore, I release the lien holder and its contract representatives from all liability arising from the disclosure of health-related information under this Agreement.

Information to be Disclosed:

Lien information and confirming medical records regarding any conditional payments made, or medical care performed, by the lien holder relating to the injury or negligence charges for the period beginning with the date of incident.

This authorization will expire two (2) years from the date below.

Signature

Date