

Court's authority to direct and control the coordinated discovery in this litigation pursuant to 28 U.S.C. §1407, Fed.R.Civ.P. 16 and Fed.R.Civ.P. 26(b), and the Court's inherent authority regarding case-specific discovery in this MDL.

2. *Claimants Affected by this Order.* This Order applies to all claims submitted to the Vioxx Resolution Program. This includes cases originally transferred to this Court by the Judicial Panel on Multidistrict Litigation pursuant to its Order of July 6, 2006 or as tag-along actions, and all related cases originally filed in this Court or transferred or removed to this Court. This Order also applies to all cases tolled pursuant to Tolling Agreement, entered into by Merck & Co., Inc. and the MDL PSC on June 1, 2005.

3. *Discovery Affected by this Order.* This Order applies to the procurement of information and materials from entities (including but not limited to physicians, healthcare providers, pharmacies, educational facilities, former and present employers, insurance providers, all branches of the military and any other federal, state, and/or local government agencies) relating to claimants referred to in Paragraph 2.

4. *Duty to Accept Court-Approved Authorization to Release Medical Records and Employment Records.* The Authorization Forms attached to this Order are HIPAA compliant and have been approved for use in all claims affected by this Order. Accordingly:

- (a) All physicians, healthcare providers, pharmacies, pharmacy benefits managers ("PBM"), educational facilities, former and present employers, insurance providers, all branches of the military, any federal, state, and/or local government agencies, or any other entity asked to produce records relating to a plaintiff or employee(all referred to as "Entities") shall accept the Authorization Forms as valid for all claims affected by this Order;
- (b) Entities may not request or insist upon different forms or terms different from the Authorization Forms;
- (c) When signed by a patient or employee and plaintiff in claims affected by this Order, the Authorization Forms shall be relied upon by all Entities to authorize the release of all records, including all medical and psychiatric records;
- (d) No facility-specific or different form shall be necessary for production of any records relating to a current or former patient or employee;
- (e) A photocopy or pdf image of the Authorization Forms shall be accepted;
- (f) No original signatures shall be required on the Authorization Forms for production of any records relating to a current or former patient or employee;

- (g) Any Authorization Form dated after November 9, 2007, shall be effective for production of any records relating to a current or former patient or employee and no differently dated Authorization shall be necessary or requested by the Entities;
- (h) Entities may not impose any waiting period for the production of records; and
- (i) Entities may not condition the release of requested records upon the payment of unreasonable “processing” or “handling” fees.

New Orleans, Louisiana, this 10th day of April, 2008.

A handwritten signature in black ink that reads "Eldon E. Fallon". The signature is written in a cursive style with a horizontal line underneath it.

ELDON E. FALLON
UNITED STATES DISTRICT JUDGE

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

Patient Name	Last	First	Middle
Date of Birth	____/____/____ (Month/Day/Year)	Social Security Number	____-____-____
Litigation Case No.			
Records Provider(s)			
1.	I hereby authorize the Records Provider(s) identified above to release all existing medical records regarding the above-named person's medical care, treatment, physical condition, and/or medical expenses to BrownGreer PLC, its agents, servants, employees and independent auditors, the medical or other documentation required to consider claims in the settlement Program under the Settlement Agreement dated November 9, 2007 (the "Program"). These records shall be used or disclosed solely in connection with the currently pending Vioxx litigation or the Program 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 or claim 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 claim.		
2.	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.		
3.	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, Forms, 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.		
4.	I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by BrownGreer PLC to the Courts presiding over the Program, Merck & Co., Inc., the Special Master (and any Deputy Special Master), the Chief Administrator, members of the Gate Committee, and the Lien Resolution Administrator for the Program and all other persons provided for under the terms of the Agreement to consider claims in the Program, and their respective attorneys, agents, employees, consultants, independent auditors, and experts (the "Receiving Parties"), and others deemed necessary by the Receiving Parties to assist in this litigation or claim and may no longer be protected by HIPAA. This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above Receiving Parties until the conclusion of the litigation or claim. 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		

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

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 reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation or claim that is disclosed to the Receiving Parties.

5. 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 the party sending you this Authorization.

Date	____/____/____ (Month/Day/Year)	Signature	_____ [PATIENT OR REPRESENTATIVE]
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Print Name	
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If you are signing this Authorization as a representative on behalf of the patient identified at the top of this Form, describe your relationship to the patient and your authority to act on his/her behalf:

You must attach proper documentation (e.g., Power of Attorney, Letters of Administration) authorizing you to act in this representative capacity.

ATTACHMENT D TO ENROLLMENT FORM

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

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Litigation Case No. _____

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 to _____ [Merck & Co.,Inc., the Claims Administrator, the Special Master (and any Deputy Special Master) for the Program, the Chief Administrator for the Program, members of the Gate Committee for the Program, all other persons provided for under the terms of the Agreement to consider claims], and their respective attorneys, agents, servants, employees and independent auditors, the medical or other documentation required for approval of an award under the Program. These records shall be used or disclosed solely in connection with the currently pending Vioxx litigation or claims Resolution Program under the Settlement Ageement dated November ___, 2007, 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 or claim 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 claim.

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, Forms, 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 Receiving Parties until the conclusion of the litigation or claim. 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 re-disclosure by the recipient to its clients, agents, employees, consultants, experts, the court, Special Masters and others deemed necessary by the Receiving Parties to assist in this litigation or claim 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 or claim 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 [Claims Administrator] or Merck & Co., Inc..

Dated this _____ day of _____, 200__

Signature: _____
[PATIENT OR REPRESENTATIVE]

Print Name: _____

If you are signing this authorization as a representative on behalf of the patient identified at the top of this form, please describe your relationship to the patient and your authority to act on his/her behalf:

You must attach proper documentation (e.g., power of attorney, letters of administration) authorizing you to act in this representative capacity.

**AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS
(For claims of lost wages, earnings or earning capacity)**

Employee's Name	Last	First	Middle
Date of Birth	____/____/____ (Month/Day/Year)	Social Security Number	____-____-____
Litigation Case No.			
Records Provider(s)			

1. I hereby authorize the Records Provider(s) identified above to release all existing records and information in its possession regarding the above-named person's employment, income and education to BrownGreer PLC, its agents, servants, employees and independent auditors, consider claims in the settlement Program under the Settlement Agreement dated November 9, 2007 (the "Program"). These records shall be used or disclosed solely in connection with the currently pending Vioxx litigation or claim 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 or claim concludes.
2. 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.
3. 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 the party sending you this Authorization.
4. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by BrownGreer PLC to the Courts presiding over the Program, Merck & Co., Inc., the Special Master (and any Deputy Special Master), the Chief Administrator, members of the Gate Committee, and the Lien Resolution Administrator for the Program and all other persons provided for under the terms of the Agreement to consider claims in the Program, and their respective attorneys, agents, employees, consultants, independent auditors, and experts (the "Receiving Parties"), and others deemed necessary by the Receiving Parties to assist in this litigation or claim.

Date	____/____/____ (Month/Day/Year)	Signature	_____
		[EMPLOYEE OR REPRESENTATIVE]	

Print Name	_____
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If you are signing this Authorization as a representative on behalf of the employee identified at the top of this Form, describe your relationship to the employee and your authority to act on his/her behalf:

You must attach proper documentation (e.g., Power of Attorney, Letters of Administration) authorizing you to act in this representative capacity.

ATTACHMENT E TO ENROLLMENT FORM

**AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS
(For claims of lost wages, earnings or earning capacity.)**

Employee's Name: _____

Date of Birth: _____

Social Security Number: _____

Litigation Case No. _____

I hereby authorize

to release all existing records and information in its possession regarding the above-named person's employment, income and education to _____ [Merck & Co., Inc., the Claims Administrator, the Special Master (and any Deputy Special Master) for the Program, the Chief Administrator for the Program, members of the Gate Committee for the Program, all other persons provided for under the terms of the Agreement to consider claims] ("Receiving Parties"). These records shall be used or disclosed solely in connection with the currently pending Vioxx litigation or claim 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 or claim 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 [Claims Administrator] or Merck & Co., Inc..

Dated this _____ day of _____, 200__

Signature: _____
[*PATIENT OR REPRESENTATIVE*]

Print Name: _____

If you are signing this authorization as a representative on behalf of the employee identified at the top of this form, please describe your relationship to the employee and your authority to act on his/her beh

You must attach proper documentation (e.g., power of attorney, letters of administration) authorizing you to act in this representative capacity.