IN THE COURT OF COMMON PLEAS OF
PHILADELPHIA COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

IN RE: HYDROXYCUT LITIGATION (MASS TORT PROGRAM)	MAY TERM, 2010 NO. 002564

The Court hereby enters the following Pretrial Order:

I. PLAINTIFF'S FACT SHEET

On May 17, 2010, a Plaintiff's Fact Sheet, submitted by joint motion of the parties, was approved by the MDL Court in the related litigation of *In re: Hydroxycut Marketing and Sales Practice Litigation*. A copy of the approved Plaintiff's Fact Sheet is attached hereto as Exhibit "A."

It is hereby **ORDERED** that the Plaintiff's Fact Sheet is **APPROVED** and each plaintiff claiming personal injury in this litigation will complete and serve a Fact Sheet and provide the documents and authorizations according to its instructions within sixty (60) days of the date of service of any responsive pleading to Plaintiff's Complaint..

It is **FURTHER ORDERED** that Plaintiffs in cases that were filed and served before the entry of this Order will complete and serve a Fact Sheet within sixty (60) days of the entry of this Order.

DOCKETED
COMPLEX LIT CENTER
JUN 24 2010
J. STEWART

In Re: Hydroxycut Litigation-ORDER

10050256400002

COPIES SENT PURSUANT TO Pa.R.C.P. 236(b) D. WILLIAMS 06/30/2010

II. PROCEDURE WHERE PLAINTIFF FAILS TO COMPLETE FACT SHEET ACCORDING TO ITS INSTRUCTIONS

Counsel will meet and confer to discuss a Pre-Trial Order to provide procedures where a Plaintiff fails to complete a Fact Sheet according to its instructions in a timely manner. A proposal will be submitted to the Court in due course.

IT IS SO ORDERED this 23rd day of June, 2010.

SANDRA MAZER MOSS, J.

Exhibit “A”

In Re: Hydroxycut Litigation
United States District Court
Southern District of California
MDL-No. 2087

PLAINTIFF FACT SHEET

Each plaintiff who used Hydroxycut must complete this Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge.

If you are completing the form for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. You may attach as many sheets of paper as necessary to fully answer these questions.

I. DEFINITIONS

In filling out this Fact Sheet, please use the following definitions:

(1) "Hydroxycut" refers to Hydroxycut Regular Rapid Release Caplets®, Hydroxycut Caffeine-Free Rapid Release Caplets®, Hydroxycut Hardcore Liquid Caplets®, Hydroxycut Max Liquid Caplets®, Hydroxycut Regular Drink Packets®, Hydroxycut Caffeine-Free Drink Packets®, Hydroxycut Hardcore Drink Packets®, Hydroxycut Max Drink Packets®, Hydroxycut Liquid Shots®, Hydroxycut Hardcore RTDs®, Hydroxycut Max Aqua Shed®, Hydroxycut 24®, Hydroxycut Carb Control®, and Hydroxycut Natural®.

(2) "Hydroxycut Product(s)" are those products referenced in your Complaint and specifically refers to the product(s) which you claim caused the injuries or illness of which you complain in this lawsuit.

(3) "Health Care Provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, dental, psychiatric, mental, emotional, or psychological care or advice, and any pharmacy, weight loss center, counselor, dentist, x-ray department, laboratory, physical therapist, or physical therapy department, rehabilitation specialist, physician, psychiatrist, nurse (registered or otherwise), natural health provider, osteopath, paramedic, physiotherapist, radiologist, surgeon, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician, alternative medicine practitioner, or other persons or entities practicing any healing art or science and anyone involved in the evaluation, diagnosis, care and/or treatment of you.

(4) "Document" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes and x-rays, drawings, graphs, phono-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, through electronic devices into reasonably usable form.

If you have any Documents as defined above that you are requested to produce as part of answering this Fact Sheet or that relate to Hydroxycut Products, or the incident, injuries, claims or damages that are subject of your complaint, you must **NOT** dispose of, alter or modify these documents or materials in any way. You are also required to give all of these documents and materials to your attorney as soon as possible. Likewise, if you have any Hydroxycut Product(s) in your possession, you must **NOT** dispose of, alter or modify it in any way. You are also required to give any Hydroxycut Product(s) to your attorney as soon as possible.

You may, and should, consult your attorney if you have any questions regarding the completion of this form and/or about your obligations to comply with the instructions above.

II. CASE INFORMATION

A. Please state the following for the civil action that you filed:

1. Case Caption: ________________________

2. Civil Action No.: _____________________

3. Court in which action was originally filed: __________________________

4. The attorney(s) representing you:

a. Name(s): ____

____

b. Address(es): ____

____

____

c. Telephone Number(s):

____

____

d. Fax Number(s): ____

____

e. E-mail Address(es): ______________________________________

____

III. PERSONAL INFORMATION

A. If you are completing this Fact Sheet for yourself, please state:

1. Your Full Name (last name, first name and middle name):

____

2. Maiden Name (if applicable): ______________________

____

3. Other Names and Aliases: ______________________

____

4. Current Address: ______________________________

____

5. Beginning Date of Residence at Current Address: ____________

6. Prior Addresses from the Past 10 years (attach additional sheets as necessary):

Street Address	City, State	Dates

7. Social Security Number: ______-____-______

8. Driver's License Number(s) and State(s) of Issuance: ____________

____

9. Date and Place of Birth: ______________________

10. Gender: _____ Male _____ Female

11. Please list all e-mail accounts used by you in the past three (3) years (attach additional sheets as necessary):

E-mail Address	Dates

E-mail Address	Dates

12. Marital Status: ____________________

13. Please list your current spouse and any former spouse(s) and dates of marriage for the previous twenty (20) years:

Name of Spouse	Dates of Marriage

14. Please provide the names of all your children and their dates of birth:

Name	Date of Birth	Currently Resides in Household?

15. Please list all individuals, including children, relatives, and non-relatives, who have lived within your household at some time during the past 5 (five) years (please add additional sheets if necessary):

Name	Relation	Dates within Household

B. If you are completing this Fact Sheet in a representative capacity (on behalf of a deceased person or a minor) please state:

1. Your Name: ______________________________

2. Address: ______________________________

3. In what capacity you represent the individual: ____________________

4. If a court appointed you to act on behalf of the estate of the deceased person or minor, state the court and date of appointment and please attach a copy of the order to this Fact Sheet:

____

5. Your relationship to deceased or represented person:

____

6. If you represent a decedent's estate, state the date of the decedent's death:

____

The sections of the Fact Sheet below request information about the person who claimed to have used Hydroxycut and the Hydroxycut Product(s). If you are completing this Fact Sheet for someone else, please assume that "you" means the person who claimed to have used Hydroxycut and the Hydroxycut Product(s).

IV. EMPLOYMENT INFORMATION

A. Current or Most Recent Employer:

1. Name of Employer: ______________________________
2. Self-Employed?: ______________________________
3. Active Duty in Armed Services?: ______________________________
4. Address: ______________________________
5. Job Duties: ______________________________
6. Job Title/Position: ______________________________
7. Dates Employed: ______________________________
8. Hours Worked Per Week: ______________________________
9. Hourly Rate (U.S. dollars) or Equivalent: ______________________________
10. Annual Salary/Gross Income (most recent tax year): ______________________________
11. Days of Disability Leave within the past 10 (ten) years: ______________________________
12. Dates of Disability Leave: ______________________________
13. Terminated from Employment? Why?: ______________________________

    ____
14. Name and Position of supervisor: ______________________________

B. Are you making a claim for lost wages, lost earning capacity, or other economic loss? ☐ Yes ☐ No

IF YOU ARE MAKING A CLAIM FOR LOST WAGES, EARNING CAPACITY, OR OTHER ECONOMIC LOSS, COMPLETE SECTIONS C THROUGH G. IF NOT, SKIP TO SECTION H.

C. Employer at the time you claimed you were injured or experienced any illness of which you complain in this lawsuit:

1. Name of Employer: ______________________________

2. Self-Employed?: ______________________________

3. Active Duty in Armed Services?: ______________________________

4. Address: ______________________________

5. Job Duties: ______________________________

6. Job Title/Position: ______________________________

7. Dates Employed: ______________________________

8. Hours Worked Per Week: ______________________________

9. Hourly Rate (U.S. dollars) or Equivalent (in effect at the time of the complained-of injury):

____

10. Annual Salary/Gross Income (in effect at the time of the complained-of injury):

____

11. Days of Disability Leave in the ten (10) Years Prior to Claimed Injury:

____

12. Days of Disability Leave Since the Claimed Injury:

____

13. Dates of Disability Leave: ______________________________

14. Terminated from Employment? Why?: ______________________________

____

15. Name and Position of supervisor: ______________________________

D. Please complete the following information regarding any employers (other than your current employer and employer at the time of injury) that you have had in the last five (5) years (attach additional sheets as necessary):

1. Name of Employer: ______________________________

2. Self-Employed?: ______________________________

3. Active Duty in Armed Services?: ______________________

4. Address: ______________________

5. Job Duties: ______________________

6. Job Title/Position: ______________________

7. Dates Employed: ______________________

8. Hours Worked Per Week: ______________________

9. Hourly Rate (U.S. dollars) or Equivalent:

____

10. Annual Salary/Gross Income:

____

11. Days of Disability Leave During Employment:

____

12. Dates of Disability Leave: ______________________

13. Terminated from Employment? Why?: ______________________

____

14. Name and Position of supervisor: ______________________

E. If you are making claims for out-of-pocket expenses as a result of taking Hydroxycut Product(s), please complete the following:

1. For what? ______________________

2. Amount of Expenses or Fees: ______________________

3. Person or Company to be Paid: ______________________

F. If you are making a claim for lost wages, loss earning capacity or other economic loss, please state the amount you are claiming as lost wages or lost earnings as a result of your ingestion of Hydroxycut: ______________________

____

1. Please state how you calculated each amount: ______________________

G. If you are making a claim for lost future wages, please state the amount you are claiming: ______________________________

1. Please state how you calculated each amount: ______________

H. Please provide the following information about your education:

1. High School(s) Attended:

a. Name of High School: ______________

b. Address: ______________

c. Dates of Attendance: ______________

d. Grade(s) Completed: ______________

e. Did you graduate from high school? ☐ Yes ☐ No

f. Year Graduated: ______________

g. If you did not graduate from high school, did you get your GED (general equivalency diploma) or another diploma equivalent?

☐ Yes ☐ No

2. Did you attend school or a specialty/trade training program beyond high school?

☐ Yes ☐ No

If yes, please complete the following for each school that you attended after high school (attach additional sheets as necessary):

Name of School or Training Program	Address	Dates Attended	Degree or Certificate	Major

I. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf in the five (5) years before you took Hydroxycut through the present? ☐ Yes ☐ No

If yes, please complete the following.

Name of Company	Address

J. Have you applied for worker's compensation, social security, or state or federal disability benefits in the past ten (10) years? ☐ Yes ☐ No

If yes, please complete the following for each application.

1. Date of Application: ______________________

2. Claim or Docket Number: ______________________

3. Type of Benefits Requested: ______________________

4. Basis of Your Claim: ______________________

5. Resolution of Claim:

☐ Granted

☐ Denied

☐ Other: ______________________

6. If Denied, Reason for Denial: ______________________

7. Agency or company to which you submitted your application: __________

____

K. Were you ever rejected or discharged from the military service for any reason relating to your health or physical condition? ☐ Yes ☐ No

If yes, then state the reason for the health-related rejection or discharge and when this happened: ______________________

____

____

L. Have you ever filed a lawsuit or made a claim (including a worker's compensation claim) in the past twenty (20) years prior to the submission of this form, other than the present suit, relating to any bodily injury, illness or physical harm? [ ] Yes [ ] No

If yes, please state the court in which the lawsuit was brought and the civil action or docket number assigned to each such claim, action or lawsuit:

____

____

V. YOUR HEALTH CARE PROVIDERS

A. Please provide the following information for each Health Care Provider that you have seen or who has treated you during the last ten (10) years (attach additional sheets as necessary):

Name of Health Care Provider	Address and Telephone	Reason for Visit	Date(s) Seen

B. Please provide the following information for all pharmacies where you have had prescriptions filled in the past ten (10) years (attach additional sheets as necessary):

Name of Pharmacy	Address	Telephone

Name of Pharmacy	Address	Telephone

VI. YOUR MEDICAL BACKGROUND

A. Height: _______________

B. Weight (current): _______________

C. Provide the following information for each hospitalization that you have had in the past ten (10) years (attach additional sheets as necessary):

Name of Hospital	Address	Approximate Date(s)	Reason for Stay

D. Please complete the following information for each surgery that you had in the past ten (10) years (attach additional sheets as necessary):

Name of Hospital	Address	Approximate Date(s)	Reason(s) for Stay

E. Have you been treated by any Health Care Provider for any condition involving your liver in the past ten (10) years?

☐ Yes ☐ No

F. Have you been treated by any Health Care Provider for any condition involving your muscles in the past ten (10) years?

☐ Yes ☐ No

G. Have you been treated by any Health Care Provider for any condition involving your kidneys in the past ten (10) years?

☐ Yes ☐ No

H. Have you been treated by any Health Care Provider for any condition involving your brain in the past ten (10) years?

☐ Yes ☐ No

I. Have you been treated by any Health Care Provider for any condition involving your blood vessels in the past ten (10) years?

☐ Yes ☐ No

J. Have you been treated by any Health Care Provider for any condition involving your gallbladder, pancreas, or spleen in the past ten (10) years?

☐ Yes ☐ No

K. Have you been treated by any Health Care Provider for any condition involving your heart in the past ten (10) years?

☐ Yes ☐ No

L. Have you been treated by any Health Care Provider for any condition involving your gastrointestinal system—e.g., your stomach, intestines, and rectum—in the past ten (10) years?

☐ Yes ☐ No

M. Have you been treated by any Health Care Provider for any condition involving your skin—other than common scratches, cuts, or bruises—in the past ten (10) years?

☐ Yes ☐ No

N. Have you been treated by any Health Care Provider for any condition involving your immune system in the past ten (10) years?

☐ Yes ☐ No

O. Have you been treated for hypertension (high blood pressure) within the past ten (10) years?

☐ Yes ☐ No

P. If you replied Yes to any of the questions in E through O above, please complete the following information (attach additional sheets as necessary).

Condition	Treating or Monitoring Health Care Provider	Medication(s) or Any Other Treatment	Diagnostic Test(s), Procedure(s), and Result(s)	Location of Treatment and/or Monitoring

Q. Have you had or been diagnosed in the past ten (10) years with any health-related condition by any Health Care Provider, other than those listed in E through P above that required treatment or monitoring by a Health Care Provider?

☐ Yes ☐ No

If Yes, please complete the information in the table below (attach additional sheets as necessary):

Condition	Treating or Monitoring Health Care Provider	Medication(s) or Other Treatment(s)	Diagnostic Test(s), Procedure(s), and Result(s)	Location of Treatment and/or Monitoring

Condition	Treating or Monitoring Health Care Provider	Medication(s) or Other Treatment(s)	Diagnostic Test(s), Procedure(s), and Result(s)	Location of Treatment and/or Monitoring

R. Have you been tested for or diagnosed with any of the following infections?

☐ Yes ☐ No

If Yes, please provide the information below (attach additional sheets as necessary). An absence of a response shall be interpreted as a denial.

Infection	Date(s) of Test(s) or Diagnosis	Result of Test(s)	Treating or Monitoring Health Care Provider and Address
Hepatitis A			
Hepatitis B			
Hepatitis C			
Hepatitis D			
Hepatitis E			
Cytomegalovirus			
Epstein-Barr Virus			
Herpes Virus (Any)			
Adenovirus (Any)			
Yellow Fever Virus			
Toxoplasma			
Leptospira			
Q Fever (Coxiella			

Infection	Date(s) of Test(s) or Diagnosis	Result of Test(s)	Treating or Monitoring Health Care Provider and Address
Burnetii)			
Rocky Mountain Spotted Fever (Rickettsial Infection)			
HIV			
Salmonella			
Campylobacter			
Listeria			
Coxiella (Any)			
Syphilis			

S. Have you been tested for or diagnosed with any of the following conditions?

☐ Yes ☐ No

If Yes, please complete the following information (attach additional sheets as necessary. Absence of a response shall be interpreted as a denial.

Condition	Date(s) of Test(s) or Diagnosis	Result of Test(s)	Treating or Monitoring Health Care Provider and Address
Fatty Liver Disease			
Obesity			
Autoimmune Hepatitis			
Primary Biliary Cirrhosis			

Condition	Date(s) of Test(s) or Diagnosis	Result of Test(s)	Treating or Monitoring Health Care Provider and Address
Primary Sclerosing Cholangitis			
Overlap Syndrome			
Vanishing Bile Duct Syndrome			
Wilson's Disease			
Alpha-1 Antitrypsin Deficiency			
Hemochromatosis			
Alcoholism			
Alcoholic Liver Disease			
Non-Alcoholic Steatohepatitis			
Ischemic Hepatitis			
Biliary Obstruction			
Systemic Lupus Erythematosus			
Autoimmune Disease (Any Autoimmune Disease)			

T. Do you have any family history of the following conditions? Family includes, but is not limited to, immediate family members, aunts, and uncles.

☐ Yes ☐ No

If Yes, please provide the information below (attach additional sheets as necessary). An absence of a response shall be interpreted as a denial.

Condition	Family Member	Relation to You
Ulcerative Colitis		
Crohn's Disease		
Systemic Lupus Erythematosus		
Autoimmune Disorder (Any)		
Metabolic Disorder (Any)		
Hepatitis		
Hepatitis Virus Infection		
Alcoholism		
Skeletomuscular Disease (Any)		

U. Do you currently smoke or have you smoked in the past ten (10) years prior to your claimed injury?

☐ Yes ☐ No

If Yes, please describe your smoking history, including what you smoke, how much, and how long (attach additional sheets as necessary).

____

____

V. Do you currently consume alcohol or have you consumed alcohol during the ten (10) years prior to your claimed injury?

☐ Yes ☐ No

If Yes, please describe your alcohol consumption history, including what you consume, how much, and how long (attach additional sheets as necessary).

____

____

W. Do you currently consume or use illicit drugs or substances or have you consumed or used illicit drugs and substances during the ten (10) years prior to your claimed injury?

☐ Yes ☐ No

If Yes, please describe your consumption or use history, including what you consume(d) or use(d), how much, and how long (attach additional sheets as necessary).

____

____

X. Weight: Please list your weight range during the past ten (10) years: :

__________ lbs to __________ lbs

1. Weight Loss and Weight Gain: If you have experienced any weight loss and/or gain of more than five (5) pounds in any of the preceding ten (10) years, please state (a) date of such loss/gain; (b) weight noted on such date(s), (c)All facts that you know of or were told as to why you experienced such weight loss and/or gain.

Y. Are you claiming an injury from rhabdomyolysis?

☐ Yes ☐ No

If Yes, please answer the questions below (attach additional sheets as necessary).

Describe your typical exercise regimen during the 12 months before your claimed episode of rhabdomyolysis:

____

____

Describe your exercise regimen during the 4 weeks before your claimed episode of rhabdomyolysis:

____

____

Describe any changes to your exercise regimen during the 4 weeks before your claimed episode of rhabdomyolsysis:

____

List any gym, country club, or sports club memberships:

Describe any muscle or limb injury in the 12 months before your claimed episode of rhabdomyolysis:

VII. PRODUCT IDENTIFICATION

A. Have you ever taken Hydroxycut from 2004 to the present?
☐ Yes ☐ No

B. Please list the name of any Hydroxycut, including all Hydroxycut Product(s), you have taken from 2004 to the present. Include in your answer the date(s) on which you purchased the product(s), the flavor(s), bottle size(s) and lot number(s) for each product. Attach additional sheets as necessary.

Date(s)	Product(s)	Bottle Size(s) and Serving	Lot Number(s)	Vendor (where purchased)

VIII. PRODUCT INGESTION INFORMATION

A. Please identify by product name, bottle size, flavor, and lot number the Hydroxycut Product(s) you contend caused the injuries or illness of which you complain in your Complaint: ______________________________

B. Please list the date(s) on which you took the Hydroxycut Product(s) referenced in your Complaint: ____

____

C. Were you provided with any **written** instructions, warning, or other information regarding your use of Hydroxycut? ☐ Yes ☐ No

If yes, when did you receive the information? ______________________

How did you receive the instructions, warnings, or other information? ________

If you no longer have the information in your possession, please describe the written information that you received to the best of your ability:

____

Did you follow the instructions? ☐Yes ☐No

If No, please explain: ____________________________________

D. Did you receive any **oral** instructions, warnings or other information regarding your use of Hydroxycut? ☐ Yes ☐ No _____

If yes, when did you receive them? ___________________________

Who gave them to you? _________________________________

Please describe the oral instructions, warnings, or other information you received to the best of your ability:

____

____

Did you follow the instructions? ☐Yes ☐No

If No, please explain: ____________________________________

E. Please list any prescription or over the counter drug, any dietary supplement, vitamin or mineral product, herbal remedy, detoxifying solutions, alternative remedies, alternative medicines, nutriceuticals, or home remedies that you were taking at the time you were taking the Hydroxycut and Hydroxycut Product(s) referenced in your Complaint or which you took within thirty (30) days before you began ingesting the Hydroxycut and Hydroxycut Product(s) referenced in your Complaint from 2004 to present:

Name of Product	Dates(s) Taken	Prescribing or Recommending Health Care Provider	Pharmacy/Vendor Name and Address

F. If you are making a claim for physical injuries or illness from taking Hydroxycut or the Hydroxycut Product(s), please describe each:

Date of Injury or Illness	Injury or Illness	Symptoms

a. How you first became aware of the physical injuries or illness:

____

b. Whether any of those physical injuries or illnesses are still affecting you: ______________________________

____

If so, please list each: ______________________________

____

c. Prior to taking Hydroxycut Product(s) had you previously experienced any of these injuries, illnesses or symptoms in the preceding five (5) years? ☐ Yes ☐ No

If yes, please describe the injuries or illnesses or symptoms you had previously experienced and state the year(s) in which you experienced them: ______________________________
____
____

d. The number of doses of Hydroxycut Product(s) you ingested before symptoms first appeared: ______________________

(i) The ounces (or other measurement) of Hydroxycut ingested with each dose you took: ______________________

e. Did you take Hydroxycut Product(s) every day? ☐ Yes ☐ No

f. The date you stopped taking Hydroxycut Product(s) referenced in your Complaint:

g. The total does of Hydroxycut Product(s) referenced in your Complaint that you ingested from the time you first started taking it until the time you stopped taking it: ______________________

IX. PHYSICAL INJURIES, ILLNESS AND DAMAGE

A. Did you see a doctor, clinic or other Health Care Provider for the physical injuries or illnesses listed above? ☐ Yes ☐ No

If yes, please complete the following for each Health Care Provider:

Name: ______________________________
Address: ______________________________
Date of First Consultation: ______________________
Date of Most Recent Consultation: ______________________
Treatment You Received: ______________________

B. State the name of the person who referred you to the first Health Care Provider listed above: ______________________________

C. Have you had any discussions with any Health Care Provider other than those listed above, about whether Hydroxycut or the Hydroxycut Product(s) contributed to your physical injuries or illnesses? ☐ Yes ☐ No

If yes, provide the name(s): ______________________________

D. Have you undergone any testing (including but not limited to testing of hair, skin, nails, blood or urine) after you ingested Hydroxycut or the Hydroxycut Product(s)?

If yes, please complete the following:

Type of Testing: ______________________________

Date(s) of Testing: ______________________________

Name and address where tested: ______________________________

Results of testing: ______________________________

E. Has the Hydroxycut Product(s) referenced in your Complaint been tested?
☐ Yes ☐ No

If yes, please complete the following:

Type of Testing: ______________________________

Date(s) of testing: ______________________________

Name and address where tested: ______________________________

Results of testing: ______________________________

F. Are you making a claim for mental, emotional psychological, or psychiatric injuries or illness from your use of Hydroxycut Product(s)? ☐ Yes ☐ No

If yes, please complete the attached Supplemental Fact Sheet for Claims of Emotional Distress and Psychological Injuries and Harm.

G. Are there persons (other than those already identified in this Fact Sheet) whom you believe are witnesses to your claimed injuries or damages? If yes, please provide their name(s) and address(es).

1. ______________________________

2. ______________________________

3. ______________________________

X. OTHER MEDICATIONS

A. Please list any prescription or over the counter drug, any dietary supplement, vitamin or mineral product, herbal remedy, detoxifying solutions, alternative remedies, alternative medicines, nutriceuticals, or home remedies that you have used within the seven (7) years prior to your claimed injury:

Name of Drug or Other Product	Dates(s) Taken	Health Care Provider Who Prescribed or Recommended and Address	Pharmacy/Vendor Name and Address if any

B. Please review and complete **ATTACHMENT A**. Place a check mark next to each drug or substance listed below that you have taken in the last seven (7) years. For each drug or substance with a check mark, please provide the date(s) you took the medication and the reason you took the medication (attach additional sheets as necessary). Absence of a check mark shall be interpreted that you have not taken the medication in the last seven (7) years.

XI. DIET AND EXERCISE REGIMEN

A. Diet: Have you participated in any monitored, purchased, or self directed diet and/or weight loss program in the previous five (5) years?

☐ Yes ☐ No

If so, please state as to each: The business name of the program, its address , if your enrollment was at the request of any Health Care Provider (and if so, the name of such Health Care Provider), and the duration of enrollment. Describe any supplements or prescription medications used by you during your involvement in such program.

____

____

____

B. Exercise Regimen: Are you currently, or have you been during the past five (5) years, a member of any health club, gym, YMCA, or otherwise any exercise facility?

☐ Yes ☐ No

If so, state the name(s) of each , address, duration of membership:

____
____
____

XII. LOSS OF CONSORTIUM

A. If you are making a claim for loss of consortium please state all facts on which you base your claim, and all damages you claim to have suffered:

1. Please state the amount you are claiming for loss of consortium: ________

2. Are you making a claim for mental, emotional, psychological or psychiatric injuries or illness as part of your loss of consortium claim?
☐ Yes ☐ No

If yes, please complete the attached Supplemental Fact Sheet for Claims Emotional Distress and Psychological Injuries and Harm.

XIII. COMPLAINTS REGARDING HYDROXYCUT PRODUCTS

A. Have you at any time since your purchase of any Hydroxycut product sent a letter or other form of written notice, or made an oral claim or complaint, to the vendor from which you brought the product regarding your breach of warranty claims?

B. If so, please provide the date, recipient's name and address, and method of communication. In addition, please provide a copy of your letter or other form of notice

____
____
____

XIV. AUTHORIZATIONS

Complete and sign TEN ORIGINAL Authorizations for Release of Medical Records (No Psychological Injuries Claimed) in the form of attached hereto.

If you are making a claim for Lost Earnings or Lost Earning Capacity, complete and sign the attached Authorization for Release of Employment and Unemployment Records (No Psychological Injuries Claimed).

If you have filed a Worker's Compensation for Social Security disability claim, please complete and sign the attached Authorization for Release of Worker's Compensation and Social Security Records.

XV. DECLARATION

I declare under penalty of perjury that all of the information provided in the Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief, and that I have supplied all the documents requested in Part IX of this Plaintiff Fact Sheet, as required above.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are incomplete or incorrect.

Dated: ____________________ ________________________________
Signature

XVI. DEFINITIONS

In filling out this Fact Sheet, please use the following definitions:

(1) "Hydroxycut" refers to Hydroxycut Regular Rapid Release Caplets®, Hydroxycut Caffeine-Free Rapid Release Caplets®, Hydroxycut Hardcore Liquid Caplets®, Hydroxycut Max Liquid Caplets®, Hydroxycut Regular Drink Packets®, Hydroxycut Caffeine-Free Drink Packets®, Hydroxycut Hardcore Drink Packets®, Hydroxycut Max Drink Packets®, Hydroxycut Liquid Shots®, Hydroxycut Hardcore RTDs®, Hydroxycut Max Aqua Shed®, Hydroxycut 24®, Hydroxycut Carb Control®, and Hydroxycut Natural®.

(2) "Hydroxycut Product(s)" are those products referenced in your Complaint and specifically refers to the product(s) which you claim caused the injuries or illness of which you complain in this lawsuit.

(3) "Health Care Provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, dental, psychiatric, mental, emotional, or psychological care or advice, and any pharmacy, weight loss center, counselor, dentist, x-ray department, laboratory, physical therapist, or physical therapy department, rehabilitation specialist, physician, psychiatrist, nurse (registered or otherwise), natural health provider, osteopath, paramedic, physiotherapist, radiologist, surgeon, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician, alternative medicine practitioner, or other persons or entities practicing any healing art or science and anyone involved in the evaluation, diagnosis, care and/or treatment of you.

(4) "Document" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes and x-rays, drawings, graphs, phono-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, through electronic devices into reasonably usable form.

If you have any Documents as defined above that you are requested to produce as part of answering this Fact Sheet or that relate to Hydroxycut Products, or the incident, injuries, claims or damages that are subject of your complaint, you must **NOT** dispose of, alter or modify these documents or materials in any way. You are also required to give all of these documents and materials to your attorney as soon as possible. Likewise, if you have any Hydroxycut Product(s) in your possession, you must **NOT** dispose of, alter or modify it in any way. You are also required to give any Hydroxycut Product(s) to your attorney as soon as possible.

YOU MAY AND SHOULD CONSULT YOUR ATTORNEY IF YOU HAVE ANY QUESTIONS REGARDING THE COMPLETION OF THIS FORM AND/OR ABOUT YOUR OBLIGATIONS TO COMPLY WITH THE INSTRUCTIONS ABOVE.

SUPPLEMENTAL FACT SHEET FOR CLAIMS OF EMOTIONAL DISTRESS AND PSYCHOLOGICAL INJURIES AND HARM

A. Are you making a claim for mental, emotional, psychological or psychiatric injuries or illness from your use of Hydroxycut Product(s), please provide the following information: ☐ Yes ☐ No

1. Nature of illness or injury: ____________________

2. The date you first became aware of this illness or injury: ____________

3. How you first became aware of this illness or injury: ____________

4. Whether (and if so, how) this illness or injury has changed over time:

____
____
____

B. If you have seen a doctor, clinic, or any other Health Care Provider for treatment of this mental, emotional, psychological, or psychiatric injury or illness, please provide the following information:

1. Name: ________________________________

2. Address: ________________________________

3. Date of First Consultation:: ____________________

4. Date of Most Recent Consultation:: ____________________

5. Do you plan to continue to see this provider? ☐ Yes ☐ No

C. If you have experienced or have been treated for any mental, emotional, psychological, or psychiatric condition or problem (including depression) within a twenty (20) year period prior to your use of Hydroxycut, please complete the following:

1. Condition:

2. Dates of Treatment:

3. Health Care Provider (*name and address*): ____________________

____

D. DOCUMENTS

Please provide a copy of all psychiatric or psychological medical records from any Health Care Provider that treated you in the last seven (7) years.

AUTHORIZATION

Complete and sign the attached Authorization for Release of Medical Records (Psychological Injuries Claimed), and attached Authorization for Release of Employment and Unemployment Records (Psychological Injuries Claimed).

VERIFICATION

I hereby verify that all of the information provided in the Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief, and that I have supplied all the documents requested in Part IX of this Plaintiff Fact Sheet, as required above. I understand that any false statements herein are made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are incomplete or incorrect.

Dated: ____________________ ______________________________
Signature

ATTACHMENT A

Please place a check mark next to each drug or substance listed below that you have taken in the last seven (7) years. For each drug or substance with a check mark, please provide the date(s) you took the medication and the reason you took the medication (attach additional sheets as necessary). Absence of a check mark or any other notation shall be interpreted as a good faith assertion that you have not taken the medication in the last seven (7) years.

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Acarbose** (Precose)		
☐	**Acetaminophen** (Acephen, Actamin, Feverall, Q-Pap, Tactinal, Tempra, Tylenol, Uniserts, Vitapap)		
☐	**Albendazole** (Albenza)		
☐	**Allopurinol** (Zyloprim)		
☐	**Amiodarone** (Cordarone, Pacerone)		
☐	**Amitriptyline** (Vanatrip, Elavil, Endep)		
☐	**Amoxicillin** (Amoxil, Amoxil Pediatric Drops, Trimox)		

[1] Brand names are listed for convenience only. Not all marketed brand names for a given medication may be listed.

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Amphetamine Derivatives** (Adderall)		
☐	**Ampicillin** (Principen, Totacillin, Omnipen, Omnipen-N, Totacillin-N)		
☐	**Anabolic Steroids** (Anadrol-50, Oxandrin, Winstrol)		
☐	**Anti-HIV Medication(s)— Abacavir, Amprenavir, Atazanavir, Darunavir, Delavirdine, Didanosine, Efavirenz, Enfuvirtide, Emtricitabine, Etravirine, Fosamprenavir, Indinavir, Lamivudine, Lopinavir, Maraviroc, Nelfinavir, Nevirapine, Raltegravir, Ritonavir, Saquinavir, Stavudine, Tenofovir, Tipranavir, Zidovudine, Other (specify)** (Agenerase, Aptivus, Atripla, Celsentri, Combivir, Coviracil, Crixivan, Emtriva, Epivir, Epzicom, Fuzeon, Intelence, Invirase, Isentress Kaletra, Lexiva, Norvir, Prezista, Rescriptor, Retrovir, Reyataz, Selzentry, Sustiva, Trizivir, Truvada, Videx, Viracept, Viramune, Viread, Zerit, Ziagen)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Asparaginase** (Elspar)		
☐	**Aspirin**		
☐	**Atorvastatin** (Lipitor)		
☐	**Azathioprine** (Azasan, Imuran)		
☐	**Baclofen** (Lioresal)		
☐	**Bentazepam** (not marketed in U.S.)		
☐	**Benzodiazepines—e.g., Alprazolamm Clonazepam, Diazepam, Lorazepam, Midazolam, Triazolam, Other (specify)** (e.g., Ativan, Halcion, Klonopin, Valium, Versed, Xanax)		
☐	**Bromfenac** (Xibrom)		
☐	**Bupropion** (Budeprion, Wellbutrin, Zyban)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Captopril** (Capoten)		
☐	**Carbamazepine** (Carbatrol, Equetro, Tegretol, Tegretol XR, Epitol)		
☐	**Carbimazole** (Neomercazole)		
☐	**Chlormethiazole** (Heminevrin, Nevrin)		
☐	**Chlorpromazine** (Thorazine, Ormazine, Thorazine Spansule)		
☐	**Ciprofloxacin** (*Cipro, Cipro XR, Proquin XR, Cipro I.V., Cipro Cystitis Pack*)		
☐	**Clavulanic Acid (usually with other antibiotics)** (Augmentin)		
☐	**Celecoxib or Rofecoxib** (Celebrex, Vioxx)		
☐	**Clindamycin** (Cleocin)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Clopidogrel** (Plavix)		
☐	**Contraceptives (Oral or Injectable)** (e.g., Apri, Brevicon, Jolessa, Loestrin, Nortrel, Ortho-Novum, Plan B, Provera, many others)		
☐	**Cyproheptadine** (Periactin)		
☐	**Diclofenac** (Cambia, Cataflam, Voltaren, Zipsor)		
☐	**Didanosine** (Videx, Videx EC)		
☐	**Disulfiram** (Antabuse)		
☐	**Enalapril** (Vasotec)		
☐	**Erythromycin** (E.E.S granules, E.E.S. Filmtab, Ery-Tab, EryPed, Erythrocin Stearate Filmtab, PCE Dispertab)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Estrogens (alone or in combination with other hormones)** (e.g., Activella, Cenestin, Enjuvia, Estinyl, Estraderm, Estrogen Patches, Prempro, many others)		
☐	**Felbamate** (Felbatol)		
☐	**Fosinopril** (Monopril)		
☐	**Fluoxetine** (Prozac, Prozac Weekly, Rapiflux, Sarafem, Selfemra)		
☐	**Flutamide** (Eulexin)		
☐	**Gold-Based Medications (Any)** (e.g., Aurolate, Myochrysine, Ridaura)		
☐	**HAART Drugs** **(Highly Active Antiretroviral Therapy)** (see list of anti-HIV medications)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Ibuprofen** (Advil, Genpril, Ibu, Midol, Motrin, Nuprin)		
☐	**Halothane (a general anesthetic)** (Halothane)		
☐	**Herbal Products (specify)** (numerous)		
☐	**Indomethacin** (Indocin, Indocid, Indochron E-R, and Indocin-SR)		
☐	**Irbesartan** (Avapro)		
☐	**Isoniazid** (Nydrazid)		
☐	**Ketoconazole** (Nizoral)		
☐	**Leflunomide** (Arava)		
☐	**Lisinopril** (Prinivil, Zestril)		
☐	**Losartan** (Cozaar)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Lovastatin** (Altoprev, Mevacor, Altocor)		
☐	**Macrolide Antibiotics—e.g., Azithromycin, Clarithromycin, Dirithromycin, Erythromycin, Roxithromycin, Telithromycin, Other (specify)** (e.g., Azitrox, Biaxin, Dynabac, Fromilid, Klacid, Klabax, Lekoklar, Roxid, Rulid, Surlid, Sumamed, Zithromax, Zitromax)		
☐	**Mebendazole** (Vermox)		
☐	**Mesalamine** (Apriso, Asacol, Asacol HD, Lialda, Pentasa)		
☐	**Methotrexate** (Rheumatrex Dose Pack, Trexall, Folex PFS, Methotrexate Sodium, Preservative Free)		
☐	**Mianserin** (Bolvidon, Norval, Tolvon)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Minocycline** (Dynacin, Minocin, Minocin PAC, Myrac, Solodyn)		
☐	**Mirtazapine** (Remeron, Remeron SolTab)		
☐	**Nefazodone** (Serzone)		
☐	**Nitrofurantoin** (Furadantin, Macrobid, Macrodantin, Nitro Macro)		
☐	**NSAIDs—e.g., Naproxen, Sulindac, Piroxicam, Flufenamic Acid, Other (specify)** (e.g., Aleve, Clinoril, Feldene)		
☐	**Omeprazole** (Prilosec)		
☐	**Paroxetine** (Paxil, Paxil CR, Pexeva)		
☐	**Pemoline** (Cylert)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Penicillin (Any in Family of Penicillin Drugs)** (e.g., PC Pen VK, Pen-V)		
☐	**Pentamidine** (Nebupent, Pentam 300)		
☐	**Phenobarbital** (Solfoton, Luminal)		
☐	**Phenothiazines** (e.g., Compazine, Compro, Mellaril, Prolixin, Thorazine, Trilafon)		
☐	**Phenytoin** (Dilantin, Dilantin Infatabs, Dilantin Kapseals, Dilantin-125, Phenytek, Phenytoin Sodium, Prompt, Phenytoin Sodium, Prompt, Di-Phen)		
☐	**Piroxicam** (Feldene)		
☐	**Pravastatin** (Pravachol)		
☐	**Protease Inhibitors** **(specify)—e.g., Fosamprenavir, Lopinavir** (e.g., Lexiva, Kaletra)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Pyrazinamide** (e.g., Rifater)		
☐	**Rifampin** (Rifadin, Rimactane, Rifadin IV)		
☐	**Risperidone** (Risperdal, Risperdal M-Tab, Risperdal Consta)		
☐	**Ritodrine** (Yutopar)		
☐	**Sertraline** (Zoloft)		
☐	**Simvastatin** (Zocor)		
☐	**Statins** **(If not otherwise listed)** (e.g., Crestor, Lescol, Pitava)		
☐	**Sulfonamides** (Azulfidine , Azulfidine Entabs, Diamox Sequels, Gantrisin Pediatric, Sulfazine, Sulfazine EC, Truxazole, Zonegran)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Tamoxifen** (Soltamox)		
☐	**Telithromycin** (Ketek, Ketek Pak)		
☐	**Terbinafine** (Lamisil)		
☐	**Tetracyclines** (e.g., Adoxa, Brodspec, Declomycin, Myrac, Vibramycin)		
☐	**Trazodone** (Desyrel)		
☐	**Tricyclic Antidepressants—e.g., Amitriptylene, Doxepin, Nortriptylene** (e.g., Elavil, Pamelor, Sinquan)		
☐	**Trimethoprim-Sulfamethoxazole** (Bactrim, Bactrim DS, Septra, Septra DS, SMZ-TMP DS, Sulfatrim)		
☐	**Topiramate** (Topamax, Topamax Sprinkle, Topiragen)		

√	**Medication** (Brand Name(s)[1])	**Date(s)**	**Reasons for Taking Medication**
☐	**Trovafloxacin** (Trovan)		
☐	**Valproic Acid** (Depakene, Stavzor, Depacon)		
☐	**Venlafaxine** (Effexor, Effexor XR)		
☐	**Verapamil** (Calan, Calan SR, Covera-HS, Isoptin SR, Verelan, Verelan PM, Isoptin, Isoptin I.V.)		
☐	**Vitamin A** (A-25, A/Fish Oil, Aquasol A)		
☐	**Zidovudine (Azidothymidine)** (Retrovir)		

DECLARATION

I declare that I have reviewed and completed the information in **ATTACHMENT A** in good faith and that the information provided in **ATTACHMENT A** is true and correct to the best of my knowledge, information, and belief.

Further, I acknowledge that I have an obligation to supplement the responses in **ATTACHMENT A** if I learn that they are incomplete or incorrect.

Dated: ____________________ ____________________________________
Signature

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

IN RE: HYDROXYCUT MARKETING AND SALES PRACTICES LITIGATION **THIS DOCUMENT RELATES TO ALL ACTIONS**	**Case No. 09-md-2087-BTM-AJB** **Hon. Barry T. Moskowitz**

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")

TO: ______________________________
Name of Healthcare Provider/Physician/Facility

____
Address

____
City, State and Zip Code

RE: Patient Name: ______________________________
Date of Birth: ______________ Social Security Number: _____-_____-____
Address: ______________________________
____

I, ______________________, hereby authorize you to release and furnish to: ______________________________, copies of full and complete protected medical information, including the following:

For use in the In Re: Hydroxycut Marketing and Sales Practices Litigation, Case No. 3:09-md-02087-BTM-AJB. To my healthcare provider: *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me.*

- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.

- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports.

- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

- All billing information, including insurance records and Medicare/Medicaid claims applications.

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

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is not required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

______________________________	______________________________
Signature of Patient or Personal Representative	**Witness Signature**
______________________________	______________________________
Dated	Dated

____

Name of Patient or Personal Representative

Description of Personal Representative's Authority to Sign for Patient (attach documents which show authority)

This authorization is valid only for records from

Name of Healthcare Provider/Physician/Facility

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

IN RE: HYDROXYCUT MARKETING AND SALES PRACTICES LITIGATION THIS DOCUMENT RELATES TO ALL ACTIONS	Case No. 09-md-2087-BTM-AJB Hon. Barry T. Moskowitz

AUTHORIZATION FOR THE RELEASE OF MENTAL HEALTH RECORDS PURSUANT TO 45 CFR 164.508(a)(2) (HIPAA)

TO: ______________________________________
Name of Healthcare Provider/Physician/Facility

____
Address

____
City, State and Zip Code

RE: Patient Name: ______________________________________
Date of Birth: _______________ Social Security Number: _____-_____-____
Address: ______________________________________
____

I, ________________________, hereby authorize you to release and furnish to: __________________________________, copies of full and complete protected medical information, including the following:

For use in the In Re: Hydroxycut Marketing and Sales Practices Litigation, Case No. 3:09-md-02087-BTM-AJB. To my healthcare provider: *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment me. It does not permit you to be interviewed, to give any statements or supply any narrative resorts concerning your care and treatment of me*.

- All psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:
  - All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge

summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, records received by other physicians, pharmacy and prescription records, billing records and records of billing to third party payers and payment or denial of benefits.

This protected health information is disclosed for the following purposes: The currently pending litigation involving the person named above.

This authorization is given in compliance with 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above- entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____
Name of Representative

____
Representative Capacity (e.g. attorney, records requestor, agent, etc.

____
Street Address

____
City, State and Zip Code

I acknowledge that I have the right to revoke this authorization by written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

I understand that the nature of this authorization is to authorize the release of my mental health records.

Signature of Patient or Personal Representative

Dated

Name of Patient or Personal Representative

Description of Personal Representative's Authority to
Sign for Patient (attach documents which show authority)

Witness Signature

Dated

This authorization is valid only for records from

Name of Healthcare Provider/Physician/Facility

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

IN RE: HYDROXYCUT MARKETING AND SALES PRACTICES LITIGATION THIS DOCUMENT RELATES TO ALL ACTIONS	Case No. 09-md-2087-BTM-AJB Hon. Barry T. Moskowitz

LIMITED AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Including Mental Health Records)

TO: ____
Name

____
Address

____
City, State and Zip Code

RE: Patient Name: ____________________________________
Date of Birth: _______________ Social Security Number: _____-_____-____
Address:____
____

I, ________________________, hereby authorize you to release and furnish to: ____________________________________, copies of full and complete protected medical information, including the following:

For use in the In Re: Hydroxycut Marketing and Sales Practices Litigation, Case No. 3:09-md-02087-BTM-AJB. This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me.

- Copies of all applications for employment, unemployment benefits, resumes, records of all positions held, job descriptions of *positions* held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, psychiatric, nurse and dental records, x- rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires,

records of payments made to me or on my behalf, and any other records relating to my employment with the above-named institution, including records for treatment of psychological, psychiatric or emotional problems concerning

____

Name of Employee

Whose date of birth is ________________ and whose social security number is _____________

I understand that the information in my employment and unemployment 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.

You are authorized to release the above records to the following representatives of defendants in the above- entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____

Name of Representative

____

Representative Capacity (e.g. attorney, records requestor, agent, etc.

____

Street Address

____

City, State and Zip Code

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to your records custodian. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this employment and unemployment information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my employment and unemployment information, I can contact the releaser indicate above.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

___________________________________ ___________________________________

Signature of Patient or Personal Representative

____
Dated

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority to Sign for Patient (attach documents which show authority)

This authorization is valid only for records from

Witness Signature

____
Dated

____
Name of Healthcare Provider/Physician/Facility

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff's Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

IN RE: HYDROXYCUT MARKETING AND SALES PRACTICES LITIGATION **THIS DOCUMENT RELATES TO ALL ACTIONS**	**Case No. 09-md-2087-BTM-AJB** **Hon. Barry T. Moskowitz**

LIMITED AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Excluding Mental Health Records)

TO: ______________________________
Name of Healthcare Provider/Physician/Facility

____
Address

____
City, State and Zip Code

RE: Patient Name: ______________________________
Date of Birth: ______________ Social Security Number: _____-_____-____
Address: ______________________________
____

I, ______________________, hereby authorize you to release and furnish to:
______________________________, copies of full and complete protected medical information, including the following:

For use in the In Re: Hydroxycut Marketing and Sales Practices Litigation, Case No. 3:09-md-02087-BTM-AJB. T*this authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- Copies of all applications for employment, unemployment benefits, resumes, records of all positions held, job descriptions of *positions* held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, nurse and dental records, x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to my employment

____
Name of Employee

Whose date of birth is ______________ and whose social security number is ____________

I understand that the information in my employment and unemployment records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse.

You are authorized to release the above records to the following representatives of defendants in the above- entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____
Name of Representative

____
Representative Capacity (e.g. attorney, records requestor, agent, etc.

____
Street Address

____
City, State and Zip Code

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to your records custodian. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this employment and unemployment information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my employment and unemployment information, I can contact the releaser indicate above.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

_______________________	_______________________
Signature of Patient or Personal Representative	**Witness Signature**
_______________________	_______________________

Dated

Dated

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority to Sign for Patient (attach documents which show authority)

This authorization is valid only for records from

____
Name of Healthcare Provider/Physician/Facility

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff's Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

IN RE: HYDROXYCUT MARKETING AND SALES PRACTICES LITIGATION THIS DOCUMENT RELATES TO ALL ACTIONS	Case No. 09-md-2087-BTM-AJB Hon. Barry T. Moskowitz

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Including Mental Health Records)

TO: ______________________________
Name of Healthcare Provider/Physician/Facility

____
Address

____
City, State and Zip Code

RE: Patient Name: ______________________________
Date of Birth: ____________ Social Security Number: _____-_____-_____
Address: ______________________________
____

I, ____________________, hereby authorize you to release and furnish to: ____________________________, copies of full and complete protected medical information, including the following:

For use in the In Re: Hydroxycut Marketing and Sales Practices Litigation, Case No. 3:09-md-02087-BTM-AJB. *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me.*

- Copies of all applications for employment, unemployment benefits, resumes, records of all positions held, job descriptions of positions held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, nurse and dental records, x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of

payments made to me or on my behalf, and any other records relating to my employment with the above-named institution.

____
Name of Employee

Whose date of birth is ______________ and whose social security number is ____________

I understand that the information in my employment and unemployment records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse.

You are authorized to release the above records to the following representatives of defendants in the above- entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____
Name of Representative

____
Representative Capacity (e.g. attorney, records requestor, agent, etc.

____
Street Address

____
City, State and Zip Code

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to your records custodian. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this employment and unemployment information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my employment and unemployment information, I can contact the releaser indicate above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is not required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

______________________________ **Signature of Patient or Personal Representative**	______________________________ **Witness Signature**
______________________________ Dated	______________________________ Dated
______________________________ Name of Patient or Personal Representative	
______________________________ Description of Personal Representative's Authority to Sign for Patient (attach documents which show authority)	
This authorization is valid only for records from	______________________________ Name of Healthcare Provider/Physician/Facility

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff's Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

IN RE: HYDROXYCUT MARKETING AND SALES PRACTICES LITIGATION THIS DOCUMENT RELATES TO ALL ACTIONS	Case No. 09-md-2087-BTM-AJB Hon. Barry T. Moskowitz

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Including Mental Health Records)

TO: Social Security Disability ____________________

____
Address

____
City, State and Zip Code

RE: Patient Name: ____
Date of Birth: ________________ Social Security Number: ______-______-______
Address:____
____

I, ________________________, hereby authorize you to release and furnish to: ___________________________________, copies of full and complete protected medical information, including the following:

For use in the In Re: Hydroxycut Marketing and Sales Practices Litigation, Case No. 3:09-md-02087-BTM-AJB. *This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me*.

- All Social Security Disability records.
- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.

- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports.

- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

- All billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits.

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

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

______________________________	______________________________
Signature of Patient or Personal Representative	**Witness Signature**
______________________________	______________________________
Dated	Dated

____

Name of Patient or Personal Representative

____

Description of Personal Representative's
Authority to Sign for Patient (attach documents
which show authority)

This authorization is valid only for records
from

____
Name of Healthcare Provider/Physician/Facility

This authorization is valid only for records from Social Security Disability.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

IN RE: HYDROXYCUT MARKETING AND SALES PRACTICES LITIGATION **THIS DOCUMENT RELATES TO ALL ACTIONS**	**Case No. 09-md-2087-BTM-AJB** **Hon. Barry T. Moskowitz**

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA")
(Excluding Mental Health Records)

TO: Social Security Disability____________________

____
Address
____
City, State and Zip Code

RE: Patient Name: ________________________________
Date of Birth: ______________ Social Security Number: _____-_____-_____
Address:___________________________________
____

I, ______________________, hereby authorize you to release and furnish to: ________________________________, copies of full and complete protected medical information, including the following:

For use in the In Re: Hydroxycut Marketing and Sales Practices Litigation, Case No. 3:09-md-02087-BTM-AJB. This authorization is forwarded by attorneys for the defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit ou, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me.

- All Social Security Disability records.

- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.

- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (My).). It may also include information about treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at conclusion of individual plaintiff litigation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile or copy of authorization shall have same force as an original.

______________________________	______________________________
Signature of Patient or Personal Representative	**Witness Signature**
______________________________	______________________________
Dated	Dated

____
Name of Patient or Personal Representative

____

Description of Personal Representative's
Authority to Sign for Patient (attach documents
which show authority)

This authorization is valid only for records
from ______________________________

Name of Healthcare Provider/Physician/Facility

This authorization is valid only for records from Social Security Disability.