"Veterans for Veterans"

WHAT WE NEED FROM YOU TO EVALUATE AND PURSUE YOUR CLAIM

1. **CONTINGENCY FEE AGREEMENT "CFA"**– The CFA is the contract between you "the injured party" and BLALOCK LLC "the Firm." This agreement states that we will represent you at no initial cost to you. We do not represent you until we receive this document from you. Any payment to our Firm will only come from any award we may achieve for you at a future date.

2. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT "HIPAA"** – The two HIPAA forms serve as releases that allow your healthcare provider(s) to provide records for review by our team. This review is necessary to evaluate and pursue your claims. Please **only** add your **personal information (Name, SSN, and DOB) then sign and date** at the bottom of the forms (including your relationship to the injured party if signed by personal representative). Do not put dates, Doctor's names, hospitals, or check any boxes (our staff will complete these sections). These are highly important documents and must be completed correctly.

3. **ELECTRONIC COMMUNICATIONS CONSENT** – By signing the consent to Receive Electronic Communications, you authorize our Firm, staff and designated vendors to communicate with you electronically (as opposed to sending correspondence through the mail) using the email and text address you provide, in accordance with the terms of the consent.

If you have any questions regarding this process or the forms specifically, please contact Carla Baker at carla@blalocklegal.com or (205) 201-0264.

PO BOX 382434 BIRMINGHAM, AL 35238
2001 PARK PLACE NORTH, SUITE 1000 BIRMINGHAM, AL 35203
T 205-201-0264 U WWW.BLALOCKLEGAL.COM

"Veterans for Veterans"

CONTINGENT FEE AGREEMENT

Dated _____

The Client:

(Name) _____

(Address) _____

(Tele. #) _____

(Email) _____

(SSN) _____

retains BLALOCK, LLC, hereinafter the "Firm":

Blalock LLC
P.O. Box 382434
Birmingham, Alabama 35238-2434

to perform the legal services as further described below. The claim, controversy, and other matters to which the services are to be performed include personal injury claims for damages arising out of exposure to contaminated groundwater at Camp LeJeune, North Carolina. The Firm will not pursue medical malpractice claims. The representation will not include the handling of counterclaims or third-party claims to amounts recovered.

1. CONTINGENCY

The contingency upon which compensation is to be paid is the client's recovery of funds by settlement or judgment.

2. CLIENT'S LIABILTY TO PAY COMPENSATION

The Client is not to be liable to pay compensation otherwise than from amounts collected for the Client by the Firm except as follows:

In the event the Client terminates this Contingent Fee Agreement without wrongful conduct by the Firm (conduct which would cause the Firm to forfeit any fee), or if the Firm justifiably withdraws from the representation of the Client, or if the parties mutually agree to terminate this agreement, the Firm may ask the court or other tribunal to order the Client to pay the Firm a fee

based upon the reasonable value of the services provided by the Firm. If the Firm and the Client cannot agree how the Firm is to be compensated in this circumstance, the Firm will request the court or other tribunal to determine: (1) if the Client has been unfairly or unjustly enriched if the Client does not pay a fee to the Firm; (2) the amount of the fee owed, taking into account the nature and complexity of the Client's case, the time and skill devoted to the Client's case by the Firm, and the benefit obtained by the Client as a result of the Firm's efforts, and (3) prejudice to the Firm if no fee is paid. Any fee awarded shall be payable only from the gross recovery obtained by or on behalf of the Client and the amount of such fee shall not be greater than the fee that would have been earned by the Firm if the contingency described in this Contingent Fee Agreement had occurred.

3. PERCENTAGE OF GROSS AMOUNT COLLECTED

Executing this Agreement commences the legal representation, and the Client will pay the Firm thirty-three and one-third (33.3%) percent of the gross amount collected. "Gross amount collected" means the amount collected before any subtraction of expenses and disbursements. ("Net amount collected" means the amount of the collection remaining after subtraction of expenses and disbursements including costs or attorney fees awarded to an opposing party and against the Client). At times, in centralized cases, a Court will order a common benefit assessment to be paid from the fee. That common benefit assessment, if any, shall be borne by Client and Firm and shall be taken from the gross amount collected before the attorney fee percentage is calculated.

The Firm reserves the right to associate with other firms and attorneys should the Firm deem necessary and a benefit to the litigation. Retaining additional firms or attorneys will NOT result in additional attorney fees owed. If federal or state law or judicial order cap or limit attorney fees in any way, we will comply with such laws and orders and adjust the fee appropriately.

4. FEES AND COSTS AWARDED TO OPPOSING PARTY

There is a possibility that a court will award costs or attorney fees in favor of or against the Client. Costs and attorneys' fees, if any, awarded to an opposing party against the Client will be paid by the Client when ordered. Any award of costs or attorneys' fees in Client's favor, regardless of when awarded, will not be subtracted from the amount collected before computing the amount of the contingent fee under this agreement.

5. EXPENSES

The Client is to be liable to the Firm for reasonable expenses and costs incurred in litigating client's claim. Rather than having the Client reimburse the Firm out of pocket each month, the Firm will advance and pay all reasonable expenses. The Client will reimburse the Firm for such expenditures from his/her share of the recovery upon final resolution. If the Firm does not obtain a recovery for the Client, the Client has no obligation to reimburse the Firm its expenses. The Client will have an opportunity to review and approve the final expenses before any reimbursement.

Expenses shall include, but not be limited to, cash and noncash expenditures for filing fees; subpoenas; depositions; witness fees; in-house and outside investigation services; expert witness fees; medical records and reports; computer research and on-line service costs; photographs; in-house and outside photocopies; facsimiles; long-distance telephone calls; postage and federal express, UPS and other overnight service charges; mediation fees; travel costs; airline tickets; out-of-town hotel; food and transportation charges; in-house and outside trial exhibits; in-house and outside multi-media services; outside legal fees and costs for estate, guardianship, bankruptcy and probate matters; outside required services from experts or vendors or other similar company; outside resolution costs for allocation and oversight, and all other costs necessary for performance of legal services. Costs shall also specifically include, if applicable, any assessment imposed by any Multi-District Litigation Court or State Court Consolidation Centralization or withheld from any settlement or favorable judgment by any defendant.

In addition to the above listed individual expenses, the Firm also charges common benefit costs to clients who are part of a class action or who also have individual claims that are part of a mass tort action. Common benefit costs are costs expended by the Firm for the common benefit of a group of clients. For example, if a deposition of a defendant expert witness is taken in one case, and this deposition can be used for and/or benefit the claims of many other clients, the Firm classifies these costs as common benefit costs. By using this common benefit cost system, no one client has to solely bear the costs which benefits the group as a whole, and many of the most substantial costs of litigation can be shared equally by all. Thus, to the extent such charges benefit a group of clients, common benefit charges may include postage, faxes, telephone, copies, experts, investigation, computer research, medical research, transportation, litigation group expenses and some of the costs incurred in actually trying any one client's case before a jury.

6. THIRD PARTY EXPENSES

The Client authorizes the Firm to pay from the amount collected the following: all physicians, hospitals, subrogation claims and liens (medical, lawsuit financing advances, and other liens). The Firm may be legally required by law or court order to pay the claims of third parties out of any monies collected for the Client, and not to disburse them to the Client. Should Client dispute the amount or validity of the third-party claim, the Firm shall deposit the funds into the registry of an appropriate court for determination. Any amounts paid or payable to third parties will not be subtracted from the amount collected before computing the amount of the contingent fee under this agreement.

7. MEDICAL MALPRACTICE ISSUES

The Client understands and agrees that the Firm has not been retained to investigate or pursue, and will not investigate or pursue, any medical malpractice action or any other action against our doctors.

8. TIMELINESS OF CLAIM

The Client acknowledges that the Firm must have certain information to determine whether Client has a claim and that the Firm cannot file a lawsuit without that information. The Client also acknowledges that every claim has a Statute of Limitations and if a lawsuit is not filed prior to the expiration of the applicable Statute of Limitations, the right to file a lawsuit may be gone forever. Client specifically acknowledges that, prior to filing a lawsuit, the Firm must have a copy of the clients military discharge form DD214 and other information needed in establishing Client's proof of alleged injury ("Proof of Injury"). **Client understands it could take the Firm a minimum of sixty (60) days after receipt of such information to evaluate the potential claim.**

9. DUAL REPRESENTATION

By execution of this Agreement, Client represents and warrants that they have not previously retained other counsel to represent them in this matter. If it is later determined that Client had retained counsel to represent them in this matter prior to execution of this Agreement, Client agrees that the Firm shall still be entitled to its full fee percentage and recovery of its fees and agrees to pay the Firm from their recovery in this matter or out of pocket if necessary. Client agrees to inform the Firm in writing if they retain subsequent counsel to assist and/or represent them in this matter and to provide contact information (firm name, lead attorney, phone number) of new counsel to the Firm. If Client does not so inform the Firm within 30 days of retaining subsequent counsel, Client agrees that the Firm shall still be entitled to its full fee percentage and recovery of its fees and agrees to pay the Firm from their recovery or out of pocket.

10. ASSOCIATED COUNSEL

The Client acknowledges that it may be necessary for the Firm to associate with other legal counsel and agree that the Firm's fees set forth above will include fees due associate counsel, which fees shall be divided based upon the work performed and/or obligations incurred by each participating firm. ***The Client will pay no more in fees with the inclusion of associate counsel than he or she would pay pursuant to this contract if the Firm solely represented him or her***. If the Firm wishes to hire a lawyer in another firm ("associated counsel") to assist in handling of a matter, the Firm will promptly inform the Client in writing of the identity of the associated counsel and that hiring of associated counsel will not increase the contingent fee, unless the Client otherwise agrees in writing. The Client has a right to disapprove the hiring of associated counsel and to terminate the employment of associated counsel for any reason.

The Client agrees that the Firm and associate counsel each will be responsible to represent the Client's interests. However, the Client agrees that the Firm, its attorneys and/or its employees will not be financially responsible for any wantonness, willfulness and/or intentional misconduct of associate counsel, associate counsel attorneys and/or associate counsel employees, and in no event will the Firm, its attorneys and/or employees be financially responsible for any punitive conduct and/or punitive damages arising out of the conduct of associate counsel, associate counsel attorneys and/or associate counsel employees, and/or anyone acting on the behalf of associate counsel. By executing this agreement, the client consents to retention of associated counsel.

11. SETTLEMENT PROCEDURE IN MULTIPLE CLIENT CASES

You understand that often in cases in which the Firm represents multiple clients in similar litigation, the opposing parties (the Defendants) attempt to settle the Firm's cases in groups under a "matrix type" system in which the Firm's clients are offered varying settlement amounts depending upon the circumstances of each of the clients' cases. Once a settlement value under the matrix is determined, the client is then given the opportunity to accept or reject the value being offered within the matrix system. Similarly, under some circumstances, the Defendants offer to pay a certain sum to all the Firm's clients regardless of the circumstances of the individual cases. Thus, each client receives the same amount of money even though the clients may have different levels of injuries or liability.

Regardless of what method is used, you understand that the fact that your case settles with a group of others will not take away your right to approve or not approve your individual settlement. You will always have the right to approve or not to approve your individual settlement. Because you will be given the opportunity to individually evaluate and approve any settlement wholly independent from any other Firm client that may settle in a group with you, you agree not to share any information (including, but not limited to, the nature of your injury and the settlement amount) with any other Firm client who may settle in a group with you.

12. RECOVERY

The Client expressly grants power to the Firm to endorse and deposit into the Firm's Client Trust Account any checks in the Client's name resulting from a settlement either approved by the Client or issued pursuant to a court order, and authorizes the attorneys to deduct fees, costs, disbursements and expenses, and to pay all hospital and medical bills from the Client's share of the recovery as well as litigation advances received by the client for which the Firm has notice.

13. LIMITED POWER OF ATTORNEY

Should any defendant file for bankruptcy, the Client herein grants a limited and specific power of attorney to the Firm to act as attorney in fact for the undersigned with the full power and authority to undertake and perform the following acts on my behalf: (a) to vote my vote to accept or reject any proposed Plan; (b) to prepare a ballot in order to vote on the Plan; (d) to submit that vote and ballot pursuant to procedures for voting on the Plan established by the Bankruptcy Court; and (e) to include me as part of a Master Ballot (or similar phrase) and (f) to take all actions on my behalf in the Firm's discretion necessary to vote my claim. The authority granted herein shall also include such incidental acts as are reasonably required to carry out and perform the specific authorities granted herein. The Firm agrees to accept this appointment subject to its terms and agrees to act and perform.

14. RETENTION OF CLIENT FILE

The Client understands that the client file maintained by the Firm is his or her property. However, the client also understands that the Firm will only retain the Client's file for a period of seven years after the case is completed. After the seven-year period, the entire file will be discarded, and the Firm will not retain a copy of any portion of the file. Thus, it is the Client's responsibility to seek the return of all original documents immediately after the case is completed, and to request a copy of any portions of the file the Client wishes to retain. If the Client waits more than seven years to request the file, then no portion of the file will be in existence at that time.

15. LEGAL CONSTRUCTION

In case any provision, or any portion of any provision, contained in this Agreement shall for any reason be held to be invalid, illegal and/or unenforceable in any respect, such invalidity, illegality and/or unenforceability shall not affect the validity and/or enforceability of any other provision or portion thereof, and this Agreement shall be construed as if such invalid, illegal and/or unenforceable provision or portion thereof was never contained herein. The parties to this agreement do hereby subject themselves to the personal jurisdiction of the District Court of the State of North Carolina and to the substantive and procedural laws thereof for the resolution of any disputes arising under this agreement and/or for the enforcement of any rights, duties, or obligations arising under this agreement.

16. CHANGE OF ADDRESS AND COMMUNICATION

The Client agrees to keep the Firm informed at all times of their current contact information, including address and telephone number. Often, the Firm will need to reach the Client for an update or for Client's signature on a particular document.

17. SMS/TEXT MESSAGE COMMUNICATION

Client agrees to receive communication from the Firm via e-mail and SMS or text message.

WE HAVE EACH READ THE ABOVE AGREEMENT BEFORE SIGNING IT.

BY: _____ _____

Client Date

BY: _____ _____

Attorney Date

"Veterans for Veterans"

CONFIDENTIAL DOCUMENT
SUBJECT TO FRE 408 AND STATE EQUIVALENT

DECLARATION

Pursuant to 28. U.S.C. § 1746, I declare under penalty of perjury that all information provided by me in connection with my Camp LeJeune Groundwater Exposure Claim is true and correct to the best of my knowledge, information and belief.

Date: _____ _____

Signature of Plaintiff

_____

Print Name of Signing Plaintiff

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Address: _____

Date of Birth: _____ _____

Social Security No.: _____ Phone: _____

I authorize the use or disclosure of the above-named individual's health information as described below:

1 _____ _____located at

_____ is authorized to make the disclosure.

2. For the date(s) of Service: _____ ___for the following record types:

☐ Entire Medical Record	☐ Consultation Report	☐ Pathology Report	☐ Emergency Dept. Record
☐ History and Physical	☐ EKG Report	☐ Laboratory Results	☐ Dental Records
☐ Operative Notes	☐ Nurses' Notes	☐ Imaging Results	☐ Pharmacy Records
☐ Discharge Summary	☐ Physical Therapy	☐ Client Intake Form	☐ Films/Images:
☐ Progress Notes	☐ Outpatient Record	☐ Prescriptions	☐ Itemized Billing
☐ Physician's Orders	☐ Other: _____		

_____

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or genetic testing. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I give my permission to release records related to these categories. My grant of the release of this information does not permit re-disclosure to any party or entity (including third-party insurance companies) unless I specifically authorize such release in writing, or its re-disclosure is permitted by federal or state law. _____
INITIAL

4. The information authorized for release may include records that indicate the presence of a communicable or non-communicable disease.

5. This information may be disclosed to, and used only by, the following individual(s) or organization(s) for the purpose as indicated in item 6:

c/o Consumer Attorney Record Services, 5041 Bayou Blvd, #301, Pensacola, FL 32503
Phone: 800-476-0489 | Fax: 850-912-8945 | Email: requests@carsmedrec.com

Please provide electronic records, when available to https://db.carsmedrec.com/records

6. For the purpose of: Litigation

7. I understand that I have a 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 Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.

8. Unless otherwise revoked, the authorization will expire on the following date, event, or condition: _____.

9. I understand, except as indicated, that once the information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal privacy regulations. I understand a copy of this authorization shall be valid as the original. I understand that I have the right to receive a copy of this authorization.

10. I understand that I need not sign this form to ensure healthcare treatment, payment, and enrollment in my health plan or eligibility for benefits. *OR* I understand that if I refuse to sign this form, under specific conditions the organization can refuse: Treatment, Enrollment in the Health Plan, and/or Eligibility for Benefits.

_____ _____

Signature Witness Signature

_____ _____

Print Name Date of Witness Signature

_____

If signed by Representative, Relationship to Patient

_____

Date of Signature

REQUEST No.:

CLIENT No.:

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2024

REQUEST PERTAINING TO MILITARY RECORDS

Requests can be submitted online using eVetRecs at https://www.archives.gov/veterans/military-service-records/

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE				☐	☐	
b. RESERVE				☐	☐	
c. NATIONAL GUARD				☐	☐	

6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN: 1. _____ 2. _____ 3. _____ 4. _____

7. IS THIS PERSON DECEASED? ☐ **NO** ☐ **YES** - ***MUST*** *provide Date of Death if veteran is deceased:* _____

8. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ **NO** ☐ **YES**

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation): _____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.
☐ I request inpatient/hospitalization records from _____ (facility), last treated in _____ (year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

2. PURPOSE: (Providing information about the purpose of the request is **voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. RELATIONSHIP TO VETERAN: _____

3. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)

☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)

☐ OTHER (Specify): _____

4. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

_____
Name

_____ _____
Street Address Apt. #

_____ _____ _____
City State ZIP Code

_____ _____
Daytime Phone Fax Number

_____
Email Address

5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

_____ _____
Signature Required – Do not print **Date**

* This form is available at https://www.archives.gov/veterans-military-service-records/standard-form-180.pdf on the National Archives and Records Administration (NARA) web site. *

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Prescribed by: DoDM 6025.18

CONTROLLED when filled

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and howit will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ **TO RELEASE MY PATIENT INFORMATION TO:**

(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*

☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.ss

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE		
	SPONSOR NAME:	
	SPONSOR RANK:	
	FMP/SPONSOR SSN:	
	BRANCH OF SERVICE:	
	PHONE NUMBER:	

DD FORM 2870, DEC 2003

Reset

CAMP LEJEUNE QUESTIONNAIRE

1. Today's Date: _____

2. Injured Person's Information:

   Name: _____
   Name while living at Camp Lejeune if different: _____
   Date of Birth: _____
   Martial Status: _____
   Social Security Number: _____
   Address: _____
   Phone Number: _____
   E-Mail: _____
   May we contact you by text message with case updates: _____

3. Name of the party completing this questionnaire (Skip and proceed to next questions if you are filling it out for yourself):

   Name: _____
   Address: _____
   Phone Number: _____
   E-mail: _____
   Relationship to injured person: _____
   Are you the legal guardian of injured person: _____
   May we contact you by text message with case updates: _____

4. Emergency/Secondary Contact

   Name: _____
   Address: _____
   Phone Number: _____
   E-mail: _____
   Relationship to injured person: _____
   Are you the legal guardian/personal representative of injured person: _____
   Do you have documentation proving you are the legal guardian or personal representative? _____
   May we contact this person with updates that may include medical information: _____

5. Is the Injured Person Deceased: _____
   a. If yes, what was the date of death: _____
   b. If yes, what was the cause of death: _____
   c. Do you have a copy of the death certificate? (If yes, please attached a

copy):_____

6. Why was the injured individual at Camp Lejuene? (Marine, marine dependant, civilian worker, specify other): _____

7. Estimate the first date you served, worked or lived at Camp Lejuene:
_____

8. Estimate the Last date you served, worked or lived at Camp Lejuene:
_____

9. Estimate the first and last dates you were exposed to the water (drinking, bathing, eating) at Camp Lejuene if different from Nos. 7-8, above:
_____

10. Indicate by checking the box where the injurued individual lived or worked at Camp Lejuene:
    - o Barracks
    - o Berkeley Manor
    - o Camp Geiger
    - o Courthouse Bay
    - o French Creek
    - o Hadnot Point
    - o Holcomb Boulevard
    - o Hospital Point
    - o Knox Trailer Park
    - o Mainside Barracks
    - o Midway Park
    - o Montford Point/Camp Johnson
    - o New River
    - o Onslow Beach
    - o Paradise Point
    - o Rifle Range
    - o Watkins Village
    - o Other (Specify): _____

11. After living or working at Camp Lejuene for 30 days, was the injured person diagnosed with one or more of the following:

    a. **<u>Cancers:</u>**
        1. Appendix cancer: Y/N. Best recollection of diagnosis date:_____
        2. Bladder cancer: Y/N. Best recollection of diagnosis date:_____
        3. Brain cancer: Y/N. Best recollection of diagnosis date:_____
        4. Breast cancer: Y/N. Best recollection of diagnosis date:_____
        5. Bile duct cancer: Y/N. Best recollection of diagnosis date:_____
        6. Colorectal cancer: Y/N. Best recollection of diagnosis date:_____
        7. Esophageal cancer: Y/N. Best recollection of diagnosis date:_____

8. Gallbladder cancer: Y/N. Best recollection of diagnosis date:_____
9. Intestinal cancer: Y/N. Best recollection of diagnosis date:_____
10. Kidney cancer: Y/N. Best recollection of diagnosis date:_____
11. Leukemia: Y/N. Best recollection of diagnosis date:_____
12. Liver cancer: Y/N. Best recollection of diagnosis date:_____
13. Lung cancer: Y/N. Best recollection of diagnosis date:_____
14. Multiple myeloma: Y/N. Best recollection of diagnosis date:_____
15. Non-Hodgkin's lymphoma: Y/N. Best recollection of diagnosis date:_____
16. Pancreatic cancer: Y/N. Best recollection of diagnosis date:_____
17. Sinus cancer: Y/N. Best recollection of diagnosis date:_____
18. Soft tissue sarcoma: Y/N. Best recollection of diagnosis date:_____
19. Spinal cancer: Y/N. Best recollection of diagnosis date:_____
20. Thyroid cancer: Y/N. Best recollection of diagnosis date:_____
21. Other cancer: Y/N. Best recollection of diagnosis date:_____
    - Please explain any other cancer: _____

b. **Fertility, Pregnancy issues or birth defects:**
    1. Birth Defect/Malformations:
        Y/N. Best recollection of birth date:_____
        Identify the defect/Malformation:_____
    2. Conjoined Twins:
        Y/N. Best recollection of birth date:_____
    3. Congenital malformation (microcephaly)
        Y/N. Best recollection of birth date:_____
    4. Female Infertility
        Y/N. Best recollection of date range:_____
    5. Miscarriage
        Please indicate how many miscarriages resulted:_____
        Best recollection of miscarriage dates:_____
    6. Cognitive disability
        Y/N. Best recollection of birth date:_____
        Identify the cognative disability: _____
    7. Other fertility, pregnancy issue or infant injury
        Please explain any other fertility, pregnancy issues or infant injuries:_____

c. **Other Compensable Injuries:**
    1. Amyotrophic Lateral Sclerosis (ALS):
        Y/N. Best recollection of diagnosis date:_____
    2. Aplastic anemia (and other myelodysplastic syndromes):
        Y/N. Best recollection of diagnosis date:_____
    3. Autoimmune diseases:
        Y/N. Best recollection of diagnosis date:_____
    4. Hepatic steatosis (Fatty Liver Disease):
        Y/N. Best recollection of diagnosis date:_____
    5. Multiple Sclerosis (MS):
        Y/N. Best recollection of diagnosis date:_____

6. Myelodysplastic Syndromes:
   Y/N. Best recollection of diagnosis date:_____
7. Neurobehavioral effects:
   Y/N. Best recollection of diagnosis date:_____
8. Parkinson's Disease: Y/N. Best recollection of diagnosis date:_____
9. Renal Toxicity: Y/N. Best recollection of diagnosis date:_____
10. Scleroderma: Y/N. Best recollection of diagnosis date:_____

12. Did the injured individual suffer other personal injuries not listed above? Please list:

_____
_____
_____

13. For every injury/diagnosis identified above, please identify the doctor or medical professional who diagnosed and/or treated you. Please add additional pages as necessary:

The doctor/professional diagnosed the following Injury:
_____
The doctor/professional treated the following injury:_____
Doctor/Professional Name: _____
Specialty:_____
Date range treatment rendered:_____
Facility Name:_____
Address:_____
Phone Number (if known):_____
Fax Number (if known): _____

14. Has the injured individual had surgeries as a result of the diagnosis or injury?
If yes, for each surgery please list: (1) date; (2) location of each surgery; and (3) brief description of the surgery:

_____

_____

_____

15. Identity of all hospital(s) or medical facilities not mentioned above that have rendered treatment to the injured individual for the diagnoses and/or injuries:

Hospital/Medical Facility Name: _____
Date range treatment rendered: _____
Address: _____
Phone Number (if known): _____
Fax Number (if known): _____

Hospital/Medical Facility Name: _____
Date range treatment rendered: _____
Address: _____
Phone Number (if known): _____
Fax Number (if known): _____

16. Has the injured individual ever taken medication for their injuries?
Yes/No

17. If yes, identify the pharmacy that fills and/or has filled prescriptions for the injured individual:

Pharmacy Name:_____
Address:_____
Phone Number (if known):_____
Fax Number (if known): _____

Pharmacy Name:_____
Address:_____
Phone Number (if known):_____
Fax Number (if known): _____

18. Does the injured individual receive disability benefits throught the VA?
    a. If so, how much per month?
    b. For how long has the injured person been receiving VA disability benefits?_____
    c. For what condution is the injured individual receiving VA disability benefits?
    _____

19. Has the injured individual ever received compensation for their injuries from any other

program related to Camp Lejeune drinking water? Y/N. f yes, explain_____

20. Does the injured individual have health insurance?
    a. VA/Tri-Care?
    b. Medicare? Yes/No
        i. Date(s) of eligibility (on ID card):_____
    c. Medicaid? Yes/No
        i. Date(s) of eligibility (on ID card):_____
    d. Private health insurance? Yes/No
        i. Name of Insurance Company: _____
        ii. Effective from _____ to _____

21. Is there anything else you would like us to know about your claim?

_____

_____

_____