UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF ILLINOIS

IN RE: HAIR RELAXER MARKETING SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	Case No. 23 C 818 MDL No. 3060 Judge Mary M. Rowland

CASE MANAGEMENT ORDER NO. 9
(Plaintiff Fact Sheets and Records Authorizations)

The Court hereby issues this Case Management Order to govern the form, procedure, and schedule for the completion and service of Plaintiff Fact Sheets ("PFS") and the execution of authorizations for the release of certain records.

1. **Scope.** This order applies to all plaintiffs, defendants, and their counsel in: (a) all actions transferred to *In Re Hair Relaxer Marketing Sales Practices and Products Liability Litigation* ("MDL 3060") by the Judicial Panel on Multidistrict Litigation ("JPML") pursuant to its order of February 6, 2023; (b) all related actions originally filed in or removed to this Court; and (c) any "tag-along" actions transferred to this Court by the JPML pursuant to Rules 6.2 and 7.1 of the Rules of Procedure of the JPML, subsequent to the filing of the final transfer order by the Clerk of this Court (collectively, the "Member Actions").

2. **Confidentiality.** All information disclosed on a PFS, and all related documents (including healthcare records and information) produced therewith or pursuant to an executed authorization shall be deemed confidential and treated as "Confidential Information" as required in the protective/confidentiality orders already entered in this MDL.

3. **Duty to Meet and Confer.** The Plaintiffs' counsel and Defendants' counsel shall meet and confer in a good faith effort to resolve any disputes not specifically addressed below regarding the production of documents and/or completion or service of a PFS, and/or authorizations.

4. **Admissibility.** The admissibility of information in the PFS shall be governed by the Federal Rules of Evidence and no objections are waived by virtue of any PFS response.

I. PLAINTIFF FACT SHEET AND VERIFICATIONS

1. **Plaintiff Fact Sheet.** The form PFS that shall be used in MDL 3060 and all Member Actions is attached as Exhibit A. The questions in the PFS shall be answered without objection as to relevance or the form of the question. In compliance with the deadlines set forth in Paragraph 4, every Plaintiff in each Member action shall:

a. "Substantially complete" (*see* Section 3 below for definition of "substantially complete") and contemporaneously sign and date a PFS. Plaintiff may electronically sign;

b. Execute the authorizations attached as Exhibit B; and

c. Serve the completed and executed PFS, signed authorizations, and requested documents upon counsel as set forth in Paragraph 5, below.

2. **Deadlines for PFS Submission:** For any case filed, removed or transferred to this Court, the plaintiff in each Member Action shall provide a PFS in accordance with this order on the following schedule:

a. **Cases Entering the MDL by June 30, 2023:** For any case filed, removed, or transferred to this Court on or before June 30, 2023, the plaintiff in each Member Action shall provide a PFS in accordance with this order within forty-five (45) days of entry of this order;

b. **Cases Entering the MDL Between July 1, 2023 and August 31, 2023:** For any case filed, removed or transferred to this Court between July 1, 2023 and August 31, 2023, the plaintiff in each Member Action shall provide a PFS in accordance with this order within sixty (60) days of entry of this order;

c. **Cases Entering the MDL Between September 1, 2023 and Date of the Entry of This Order:** For any case filed, removed, or transferred to this Court between September 1, 2023 and the entry of this order, plaintiffs with last names beginning with A thru L in each Member Action shall provide a PFS in accordance with this order within ninety (90) days of entry of this order while plaintiffs with last names beginning with M thru Z in each Member Action shall provide a PFS in accordance with this order within one hundred twenty (120) days of entry of this order;

d. **Cases that Enter the MDL After the Date of Entry of This Order:** For any case filed, removed or transferred to this Court on or after the date of entry of this order, the plaintiff in each Action shall provide a PFS within forty-five (45) days of service of a short form complaint and receipt of the first defendants' responsive acknowledgment.

3. **Scope of Responses.** Each plaintiff subject to this order is required to provide a PFS that is substantially complete. For a PFS to be "substantially complete" the responding plaintiff must:

a. Answer every question contained in the PFS to the best of his or her ability, providing as much information as he or she can, including by consulting non-privileged documents in his or her custody, possession, or control; a plaintiff may answer questions in good faith by indicating "not applicable," "I don't know," "I do not recall," or "unknown" where the plaintiff can provide no other information, but this does not relieve the plaintiff from providing his or her best estimate where applicable (*e.g.*, if the plaintiff cannot provide the specific date of an event, she should provide her best estimate of the date and/or a description of the time period);

b. produce all Documents (as defined in the PFS) identified in response to Section IX of the PFS;

c. produce all applicable, completed, and executed authorizations, requested in the PFS, as reflected in Exhibit B (which may be amended to reflect the identity of healthcare records collection vendors without further order of the Court); and

d. sign and date the declaration found at the end of the PFS. A plaintiff may electronically sign the PFS; however, the defendants are entitled to request, and the plaintiff must preserve certificates of completion, other metadata, or other confirmation by plaintiff approving the signature; and

e. By uploading the Fact Sheet to Third Party Vendor, Counsel certifies that they have conducted a reasonable inquiry pursuant to the Federal Rules.

4. **Amendments and Verification.** Each plaintiff shall remain under a continuing duty to supplement the information provided in the PFS pursuant to Fed. R. Civ. P. 26(e). In the event a plaintiff serves an amended PFS, that plaintiff shall clearly indicate on the face of the amended PFS that the PFS has been amended (and, if applicable, identify the iteration of the amendment (*i.e.*, "First Amended," "Second Amended," etc.)).

5. **Service of PFS.** The plaintiffs shall complete and serve their PFS, authorizations, and documents responsive to the requests for production of documents as set forth in the PFS by uploading them to their account in the database maintained by Third Party Vendor. Authorizations shall also be uploaded to the appropriate tab as separate PDFs titled with the type of authorization (*e.g.*, employment, medical, etc.) to the best of a plaintiff's ability.

6. **Treatment as Discovery Responses.** All information in a PFS or amendment thereto are binding on the responding plaintiff as if that information was provided in verified answers to interrogatories under Fed. R. Civ. P. 33. Each completed PFS or amendment thereto shall be verified (signed and dated by the plaintiff or the plaintiff's representative) as if it were

interrogatory responses provided pursuant to Fed. R. Civ. P. 33. Any requests for production of documents in the PFS shall be treated as document requests under Fed. R. Civ. P. 34. Defendants' use of the PFS is in lieu of interrogatories and requests for production of documents that Defendants otherwise would have propounded, other than additional discovery contemplated in future phases of litigation and subject to the Court's approval of same.

7. **Compliance Process.**

a. **Warning or Deficiency Letters**

i. If any plaintiff fails to serve a PFS or fails to provide any applicable authorizations by the deadline set forth in this Order, that plaintiff will receive an automated Warning Letter from the Third Party Vendor within thirty (30) days of the deadline to serve the PFS, notifying the plaintiff's attorney of record and/or their designated attorney (if applicable) of the failure to serve a PFS and/or an authorization. Plaintiffs and their counsel are responsible for ensuring appropriate contact information is provided to the Third Party Vendor to receive the automated Warning Letter.

ii. If any plaintiff fails to serve a substantially complete PFS, serve the appropriate records, or fails to provide applicable authorizations, the defendants shall designate a single defendant (the "Designated Defendant") to serve a Deficiency Letter on that plaintiff and notify the plaintiff's attorney of record and/or their designated attorney (if applicable), as well as the PLC or their designee, of the failure to serve a substantially complete PFS and/or an authorization.

1. For those cases which meet the criteria for inclusion in the bellwether selection pool, the Bellwether Protocol (to be determined in a future Case Management Order) will control PFS Deficiency timing.

2. For those cases that are outside of the criteria for inclusion in the bellwether selection pool, any Deficiency Letters must be served within six (6) months of the Bellwether Pool's selection or no later than nine (9) months after service of a PFS, whichever is later.

iii. Plaintiffs who are served with a Warning or Deficiency Letter, shall have thirty (30) calendar days from service of the Letter to serve a substantially complete PFS, and/or serve the appropriate records and/or record authorizations in accordance with this order and/or to serve any objections to the Letter.

iv. The Letter shall identify the case name, docket number, the Designated Defendant, and the thirty (30) calendar day deadline.

v. Once a plaintiff responds to a Deficiency Letter, the Designated Defendant shall not send additional Deficiency Letters identifying deficiencies related to issues not identified in the original Deficiency Letter, unless a case is selected for inclusion in a bellwether selection pool. In such a circumstance, the Designated Defendant may pursue additional deficiencies from the PFS not identified in the original Deficiency Letter, and/or may follow up further on those previously identified as part of a plaintiff's continuing obligation to supplement discovery under the Federal Rules.

b. **Obligation to Meet-and-Confer**

i. The attorney of record for the allegedly deficient plaintiff fact sheet and/or their designated attorney (if applicable) and the Designated Defendant must meet-and-confer within thirty (30) calendar days of service of the Warning or Deficiency Letter, absent agreement of the parties.

c. **PFS Compliance Meet-and-Confer amongst the Parties**

i. In addition to the individual meet and confer obligations referenced above in Section 7. b., Plaintiffs' Leadership shall designate a Plaintiffs' Compliance Liaison to organize and mediate a PFS Compliance Meet-and-Confer between plaintiff's attorney of record/designated attorney and Designated Defendant(s) for each Letter. The Plaintiffs' Compliance Liaison will also be permitted to address any failures of the Compliance and/or Deficiency process.

ii. If any plaintiff does not comply with the requirements of this order by providing a substantially complete PFS, and executing the applicable Authorizations within the thirty (30) calendar day period set forth above, the Designated Defendant may place the deficient plaintiff on a list of cases, identified by plaintiff name, case number, and attorney of record (the PFS Compliance Meet-and-Confer List). This list will be provided to Plaintiffs' Compliance Liaison at least seven (7) calendar days before the monthly PFS Compliance Meet-and-Confer between the parties' Leadership and including all applicable plaintiffs' attorneys of record and/or their designated attorney (if applicable) for resolution of remaining PFS Compliance disputes.

iii. The Designated Defendant may assign their duties pursuant to this order to another defendant at the discretion of the Designated Defendant but there shall only be one Designated Defendant at a given time.

iv. This PFS Compliance meet-and-confer will occur on an at least monthly basis and be scheduled at least ten (10) calendar days prior to any upcoming Case Management Conference. During the PFS Compliance Meet-and-Confer, the parties will discuss outstanding disputes remaining on the PFS Compliance Meet-and-Confer List.

d. **Court Call for Warning or Deficiency Resolution**

i. Following the PFS Compliance Meet-and-Confer, if the Designated Defendant still contends that any plaintiff has not complied with the requirements of this order by providing a substantially complete PFS, and executing the applicable Authorizations, or some other agreement reached between the parties, the Designated Defendant may place the alleged non-compliant plaintiff on the call docket, subjecting the plaintiff to appropriate court relief including issuing an order to show cause, compelling production and/or up to dismissal with or without prejudice.

ii. Following the PFS Compliance Meet-and-Confer and in connection with the Court's existing timeline for submitting the Parties' Status Report prior to any Case Management Conference, Defendants shall file the list of cases by plaintiff name, case number, and brief description of alleged deficiency for any cases subject to court relief (the Call Docket List).

iii. There shall be no briefing by any party.

iv. The Call Docket List will be heard at the end of the next status conference or another time determined by the Court and agreed to by the parties, which date will be published by the Court on the Court's website.

v. At the hearing, Defendants will advise the Court of any cases that may be removed from the list by agreement since the submission of the Call Docket List.

vi. At the Call Docket, each party will have the opportunity to address the Court, in person or via telephone, regarding the matter.

vii. Any plaintiff who fails to appear individually or through his or her attorney(s) at the Call Docket and establish good cause for the failure to make discovery disclosures as required herein, may be subject to an order to show cause, an order compelling production, dismissal with or without prejudice, or be subject to any other relief as the Court may order.

8. Authorizations. Plaintiffs will provide completed authorizations for all healthcare providers (including mental health providers, if applicable), and employers (if applicable) named in the PFS. In addition to the addressed authorizations:

a. Each plaintiff shall be required to execute five blank versions of the healthcare authorizations, which shall be held by the record collection vendor selected and agreed to by the parties ("Third Party Vendor"). If a plaintiff answers affirmatively to Section II.C.1 of the PFS, that plaintiff must provide two blank employer authorizations, in addition to the above. If a plaintiff answers affirmatively to Section V.K of the PFS, that plaintiff must provide two blank mental health authorizations, in addition to the above.

b. If Defendant(s) learn of a healthcare provider or employer not identified in the PFS from whom Defendant(s) want to collect records, Defendant(s) shall notify the Third Party Vendor. The Third Party Vendor shall convey that request to Plaintiff's attorney of record. Plaintiff's attorney of record shall have fourteen (14) days to approve the request, provide a completed authorization addressed to the newly identified Healthcare provider or employer, or provide written objections to the production of some or all of said records. If Plaintiff's attorney of record objects, the relevant parties shall meet and confer and, if the objection cannot be resolved, Defendants may move to compel. If Plaintiff's counsel either approves of the request or does not object within fourteen (14) calendar days, the Third Party Vendor is deemed to have authority to utilize one of the blank authorization forms to collect records from the requested provider. A plaintiff may use e-signatures or place a duplicated signature image on the authorization form in an effort to accelerate the medical records collection process.

c. In the event that all provided executed blank authorizations in a specific category (e.g. Healthcare) are used, Plaintiff's attorney of record shall replenish the authorization(s) utilized by the Third Party Vendor within fourteen (14) calendar days of the date the Third Party Vendor notifies the Plaintiff's attorney that additional authorizations are needed.

d. Defendant(s) will not utilize blank authorizations other than through the Third Party Vendor.

9. Duty to Accept Court-Approved Authorizations. The records authorization forms attached to this order (the "Authorization Forms") have been approved for use in all claims affected by this order, and the Healthcare Authorization Forms comply with the Health Insurance Portability and Accountability Act. Accordingly:

a. All physicians, healthcare providers, federal, state, and or/local government agencies, and any other entity asked to produce healthcare records relating to a claimant must accept the Authorization Forms as valid for all claims affected by this order;

b. Entities may not request or insist on forms or terms different from the Authorization Forms;

c. When signed either electronically or with wet ink signature by a plaintiff or a plaintiff's personal representative with respect to claims affected by this order, the Authorization Forms must be relied on by all entities to authorize the release of all records, including all healthcare records;

d. No facility-specific or different form may be required by any person or entity for the production of any records relating to claims affected by this order;

e. A photograph or .pdf image of the Authorization Forms must be accepted by all entities;

f. No original signatures may be required on the Authorization Forms for the production of any records by any facility, pharmacy, or other entity; and

g. Any Authorization Forms dated after the entry of this order will be effective for the production of any records relating to a plaintiff for the duration of the Member Actions.

10. Obligation to Cooperate by Providing Additional Authorizations. If Defendants wish to obtain records from a custodian who will not accept the authorizations in the form that a plaintiff executed pursuant to this order, that plaintiff will cooperate with Defendants and provide the necessary authorization(s).

11. Collection of Records. Defendants or their designee shall have the right to contact agencies, companies, firms, institutions, providers, or other records custodians to obtain a plaintiff's records or records relating to that plaintiff without further notice to the plaintiff. No interviews or discussion regarding a Plaintiff's healthcare shall be permitted during this outreach.

12. Copies of Records. Third Party Vendor shall make available for purchase by a plaintiff's counsel all records obtained by use of the plaintiff's authorizations within fourteen (14) days of the receipt of the records pursuant to the terms of the Third Party Vendor contract with the parties.

II. PHASE II FACT SHEETS

The parties shall negotiate additional document requests in Phase II that may include a plaintiff and/or defense fact sheet. These may include, but not be limited to, social media and other ESI productions from individual plaintiffs and geographic marketing information production from defendants to the extent it is not produced in general discovery.

E N T E R:

Dated: December 19, 2023

MARY M. ROWLAND
United States District Judge

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

In Re: HAIR RELAXER MARKETING SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION — MDL NO. 3060

THIS DOCUMENT RELATES TO
[PLAINTIFF NAME; MDL Case No.]

PLAINTIFF FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of HAIR RELAXER PRODUCTS by the plaintiff or the representative of a deceased plaintiff. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are providing all information under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect. "YOU" or "YOUR" shall refer to You as a Plaintiff and your legal representatives with a filed actions pending in MDL 3060, whether or not any particular underlying action has been served.

In filling out this form, please use the following definitions[1]:

(1) "**HAIR RELAXER PRODUCT"** means a product used to chemically relax hair as identified in the **Short Form Complaint**;

(2) "**OTHER HAIR CARE PRODUCTS**" means any product applied to the hair other than HAIR RELAXER PRODUCTS or OTHER HAIR TREATMENTS;

(3) "**OTHER HAIR TREATMENTS**" means any treatment to alter the natural texture of hair without the use of HAIR RELAXER PRODUCTS;

(4) "**HEALTHCARE PROVIDER**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, nurse, psychiatrist, osteopath, homeopath, chiropractor,

[1] See Dkt. 258: "As to hair relaxer kits sold to consumers, parties agree that it is limited to the kits and does not include the conditioners or shampoos that may be recommended "for best results" on the back of the kit. But the discovery will include all the products contained in the kit. As for hair relaxer products sold commercially to salons, the parties will meet and confer. Production will be limited to the products required by the label, not all products sold by the Defendant to the salon per Defendants' suggestion."

psychologist, toxicologist, nutritionist, dietician, or other person or entity involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent;

(5) "**DOCUMENT**" means any writing or record of any and every type that is in your possession, custody or control, including, but not limited to, written documents, documents in electronic format, cassettes, videotapes, digital recordings, text messages, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, telephone-records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

(6) "**RELEVANT TIME PERIOD**" means ten (10) years prior to your Injury Diagnosis.

This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery.

I. CORE CASE INFORMATION

A. Attorney Information

I. Please provide the following information for the civil action that you filed:

Caption: _____

Court and Docket No.: _____

MDL Docket No. (if different): _____

Date Lawsuit Filed: _____

Plaintiff's Attorney: _____

Attorney's Firm: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Attorney's Email Address(es): _____

B. Plaintiff Information

II. Please provide the following information for the individual on whose behalf this action was filed:

Name (First, Middle, and Last): _____

Address: _____

City: _____

State: _____

Zip code: _____

Date of Birth: _____

Place of Birth (City, State, Country): _____

Social Security Number: _____

III. Maiden or other names and aliases you have used or by which you have been known:

_____

IV. Sex: Male: ☐ Female: ☐

V. Race (Dropdown or check box; not open field): _____

VI. Ethnicity (Dropdown or check box; not open field): _____

C. Representative Information

VII. If you are completing this questionnaire in a representative capacity (*e.g.*, on behalf of the estate of a deceased person), please state the following:

Name (First, Middle, and Last): _____

Address: _____

Capacity in which you are representing the individual: _____

VIII. If you were appointed as a representative by a court, identify the state, court and case number:

_____

IX. Relationship to the represented person: _____

X. Date of death of the decedent: _____

XI. Place of death of the decedent (city, state, country): _____

If you are completing this questionnaire in a representative capacity, please respond to the questions below ***with respect to the person who was allegedly injured*** *by HAIR RELAXER PRODUCTS.*

II. PERSONAL INFORMATION

A. Relationship Information

☐Married
☐Single
☐Engaged
☐Significant other
☐Divorced
☐Widowed
☐n/a (completing on behalf of decedent)

B. Addresses

I. For ten (10) years prior to your Injury Diagnosis, please identify EACH address at which you have resided, the dates during which you lived at each address (Turn into table; not blanks):

Address: _____

From Date: _____

To Date: _____

C. Employment

I. If you are making a claim for lost wages, please complete the chart below detailing your employment history for the ten (10) years prior to your claimed injury.

Name of Employer	Address and Phone Number Where You Worked	Dates of Employment	Occupation(s) or Job Title(s)	Name of Supervisor (s)	Annual Gross Income Per Year[2]

II. Have you ever been out of work for more than thirty (30) days for reasons related to your health? Yes ☐ No☐

If yes, please state the following:

Dates: _____

Health reason:_____

D. Worker's Compensation and Disability Claims

I. Have you ever filed for workers' compensation, social security, and/or state or federal disability benefits? Yes ☐ No ☐

II. If yes, or, if you are unsure, then as to EACH application, please state the following:

Year claim was filed: _____

Court: _____

Nature of claimed injury: _____

[2] If you are making a claim for lost wages or lost earning capacity, also state your annual gross income by year:

Period of disability: _____

Amount Award: _____

E. Military Service

I. Have you ever served in any branch of the military? Yes ☐ No ☐

II. If yes, state the branch and dates of service: _____

F. Other Lawsuits

I. Have you ever filed a lawsuit or made a claim, other than in the present suit, seeking damages for the injuries you claim in this case?

Yes ☐ No ☐

II. If yes, state the following for EACH lawsuit or claim:

Nature of the case or claim: _____

Name of the defendant (person or entity you sued or filed a claim against):

_____

Civil action, docket number, or claim number: _____

Where was the lawsuit or claim was filed (court's name): _____

Name of your attorney: _____

III. Advocacy and Social Media

I. Are you now or have you ever been a member of any support, advocacy, or social group regarding your injuries you attribute to HAIR RELAXER PRODUCTS? Yes ☐ No ☐ Unknown ☐

II. If yes, identify the group by name: _____

III. Where did the group meet? _____

IV. When did you join the group? _____

V. Sponsoring organization (if any): _____

IV. Locations of Stored Data

As it relates to any Locations of Stored Data, this information is for identification purposes. For this PFS, you are required to disclose the locations of these documents, but a production shall occur (if any) if your case has been designated for Phase II Discovery (e.g., your case is included in a bellwether selection pool). You have a duty to preserve stored data and social media.

A. Identify any location, physical or electronic, containing Documents, including photographs or videos, relating to your hairstyle and/or your use of HAIR RELAXER PRODUCTS. This includes, but is not limited to, photo albums, video albums, home movies, cloud storage (including, but not limited to, Google drive and iCloud), websites, social networks (including, but not limited to, X/Twitter, Facebook, Instagram, Snapchat, TikTok, MySpace, LinkedIn, dating websites, or "blogs"), chat rooms, or internet forums. For each electronic location, identify, if applicable, a username, electronic address or URL, and state whether you have access to the location.

_____

_____

_____

_____

B. Identify any location, physical or electronic, containing Documents regarding your claimed injuries. This includes, but is not limited to, photo albums, video albums, home movies, cloud storage (including, but not limited to, Google drive and iCloud), websites, social networks (including, but not limited to, X/Twitter, Facebook, Instagram, Snapchat, TikTok, MySpace, LinkedIn, dating websites, or "blogs"), chat rooms, or internet forums. For each electronic location, identify, if

applicable, a username, electronic address or URL, and state whether you have access to the location.

C. Identify any location, physical or electronic, containing Documents regarding how you learned about the Hair Relaxer Marketing Practices and Products Liability Litigation. This includes, but is not limited to, photo albums, video albums, home movies, cloud storage (including, but not limited to, Google drive and iCloud), websites, social networks (including, but not limited to, X/Twitter, Facebook, Instagram, Snapchat, TikTok, MySpace, LinkedIn, dating websites, or "blogs"), chat rooms, or internet forums. For each electronic location, identify, if applicable, a username, an electronic address or URL, and state whether you currently have access to the location.

V. INJURIES & DAMAGES

A. For each injury you claim was caused by your use of HAIR RELAXER PRODUCTS, state:

Injury and Symptoms	Date of Diagnosis	Diagnosing Healthcare Provider, including address and telephone number	Date(s) of Treatment	Type(s) of Treatment, Dates Performed, and Treating Healthcare Provider, Including Address and Phone Number

B. For each injury, please provide the date and describe how you first became aware that it could be caused by your use of HAIR RELAXER PRODUCTS:

_____

_____

_____

C. Have you ever had any communications with any HEALTHCARE PROVIDER, orally or in writing, about whether any of the above injuries are related to your use of HAIR RELAXER PRODUCTS? Yes ☐ No ☐

If yes, or, if you are unsure, identify the name, address, phone number and approximate date of communication with said health care provider, and the injury attributed to HAIR RELAXER PRODUCTS:

_____

_____

D. Has any HEALTHCARE PROVIDER told you whether any of the above injuries is related to something other than your use of HAIR RELAXER PRODUCTS?:

Yes ☐ No ☐

If yes, or, if you are unsure, identify the name, address, telephone number and approximate date of communication with each HEALTHCARE PROVIDER and the injury attributed to something other than your use of HAIR RELAXER PRODUCTS:

_____

_____

E. Do you claim that your use of HAIR RELAXER PRODUCTS worsened a preexisting injury, illness, or disease? Yes ☐ No ☐

If yes, or, if you are unsure, for each injury, state the type of injury, illness or disease, its onset, and its resolution (if any):

_____

_____

F. If you discontinued your use of HAIR RELAXER PRODUCTS, did the injury you claim resulted from your use of HAIR RELAXER PRODUCTS decrease or resolve? Yes ☐ No ☐

If yes, or, if you are unsure, for each injury, state the type of injury, symptoms, its onset, and its resolution (if any):

_____

_____

G. Has any HEALTHCARE PROVIDER recommended that you cease using HAIR RELAXER PRODUCTS? Yes ☐ No ☐

If yes, or, if you are unsure, identify the name, address, phone number and approximate date of communication with said health care provider:

_____

_____

H. Other Claimed Damages

I. Psychiatric or Psychological Conditions: Do you claim that your use of HAIR RELAXER PRODUCTS caused or aggravated any psychiatric or psychological condition? Yes ☐ No ☐

If yes, or, if you are unsure, did you seek treatment for the psychiatric or psychological condition? Yes ☐ No ☐

Provider, Including Name, Address and Phone Number	**Date**	**Condition**

II. Medical Expenses: Do you claim that you incurred medical expenses for the alleged injury that you claim was caused by your use of HAIR RELAXER PRODUCTS? Yes ☐ No ☐

III. Lost Wages: Do you claim that you lost wages or suffered impairment of earning capacity because of the alleged injury that you claim was caused by HAIR RELAXER PRODUCTS? Yes ☐ No ☐

IV. Out-of-Pocket Expenses: Are you making a claim for lost out-of-pocket expenses? Yes ☐ No ☐

If yes, or, if you are unsure, please identify and itemize all out-of-pocket expenses you have incurred:

_____

_____

V. Loss of Consortium: Do you or any other individual claim loss of consortium damages because of the alleged injury that you claim was caused by HAIR RELAXER PRODUCTS? Yes ☐ No ☐

If yes, please identify the individual claiming loss of consortium damages, the basis for the loss of consortium claim:

_____

_____

VI. PRODUCT IDENTIFICATION

A. For each HAIR RELAXER PRODUCT you claim caused and/or contributed to your injury(ies), state:

Defendant	Product	Date(s) of Use May Be Approximate	Frequency of Use	Place(s) of Use, including state and city [if known]

B. For each injury you listed in Section VI.A. of the Plaintiff Fact Sheet in this litigation, Identify and Describe other causes known to You of such injury?

_____

_____

_____

C. Did you have any HAIR RELAXER PRODUCT, OTHER HAIR CARE PRODUCT, or OTHER HAIR TREATMENTS applied at a hair salon? (See Footnote 1 for product scope).

Yes ☐ No ☐

D. If YES, or, if you are unsure, provide in the chart below the name and location of each salon where you received application of a HAIR RELAXER PRODUCT,

OTHER HAIR CARE PRODUCT, or OTHER HAIR TREATMENTS, the dates of application and the product applied:

Date of Application **(May Be Approximate)**	**Salon**	**Salon Location – State and City [if known]**	**Hair Relaxer Product Applied**[3]

E. Retailers:

I. Identify each pharmacy, drugstore, and/or other retailer (including mail order) where you have purchased HAIR RELAXER PRODUCTS in the past ten (10) years:

Name	**Place(s) of Purchase, including business name, and including state, city and address [if known]**	**Dates**	**Purchases**

[3] See Footnote 1 for product scope.

II. Do you have a store card (including any debit, credit, or frequent buyer/loyalty card) for any retailer identified above?

Yes ☐ No ☐ Unknown ☐

If yes, state the store, card number, name and telephone number associated with the account:

_____

_____

_____

F. Have you ever seen any advertisements (*e.g.,* in magazines, television commercials, internet, radio, point of sale, social media, outdoor) for any HAIR RELAXER PRODUCT? Yes ☐ No ☐ Unable to Recall ☐

If "Yes," identify the advertisement, summary of its content, the product being advertised and approximately when you saw the advertisement.

_____

_____

_____

G. Are you currently using HAIR RELAXER PRODUCTS? Yes ☐ No ☐

H. Were you ever given any written instructions or warnings, including in/on any packaging, package inserts, or literature, regarding HAIR RELAXER PRODUCTS?
Yes ☐ No ☐ Unable to Recall ☐

If yes, please describe the instructions or warnings. If you have the instructions or warnings, please produce them:

_____

_____

_____

I. Were you given any oral instructions or warnings from any individual regarding HAIR RELAXER PRODUCTS? Yes ☐ No ☐ Unknown ☐

If yes, please identify each individual who provided the oral instructions, including their name, address, and telephone number, and identify the product and what those instructions or warning were:

_____

_____

J. For each HAIR RELAXER PRODUCT identified above in your response to VI.A., describe any risk or warning that you allege is or was not adequately disclosed on their labels:

_____

_____

_____

_____

_____

_____

K. Have You (as defined above) had any communication, oral or written, with any of the defendants regarding Hair Relaxer Products and/or your injuries, including any current or former employee or agent, or any representatives of any defendant prior October 21, 2022? Yes ☐ No ☐ Unable to Recall ☐

If yes, please identify: _____

Date of Communication: _____

Method of Communication: _____

Name of Representative: _____

Substance of communication: _____

L. Have You (as defined above) had any communication, oral or written, with any other manufacturer of HAIR RELAXER PRODUCTS (other than Defendants), regarding Hair Relaxer Products and/or your injuries including any current or

former employee or agent, or any representatives of such manufacturer prior October 21, 2022? Yes ☐ No ☐ Unable to Recall ☐

If yes, please identify: _____

Date of Communication: _____

Method of Communication: _____

Name of Representative: _____

Substance of communication: _____

M. Have You (as defined) communicated with the Food and Drug Administration, the Centers for Disease Control and Prevention, the National Institutes of Health, or any other government or regulatory agency regarding HAIR RELAXER PRODUCTS prior October 21, 2022? Yes ☐ No ☐

If yes, state the agency you communicated with, the date of the communication, and the subject of the communication.

_____

_____

_____

N. Have You (as defined above) communicated with the authors of the Chang Study,[4] the White Study,[5] or any other study cited in the Master Long Form Complaint or **Master Long Form Class** complaint filed in MDL 3060 prior to October 21, 2022? Yes ☐ No ☐ ☒

If yes, state the person(s) you communicated with, the date of the communication, and the subject of the communication.

_____

_____

_____

[4] Che-Jung Chang, et al., *Use of Straighteners and Other Hair Products and Incident Uterine Cancer*, Journal of the National Cancer Institute, Oct. 17, 2022, https://pubmed.ncbi.nlm.nih.gov/36245087.

[5] White AJ, Sandler DP, Gaston SA, Jackson CL, O'Brien KM, *Use of hair products in relation to ovarian cancer risk.* Carcinogenesis. 2021 Oct. 5; 42(9): 1189-1195. doi: 10.1093/carcin/bgab056. PMID: 34173819; PMCID: PMC8561257, https://pubmed.ncbi.nlm.nih.gov/34173819.

O. Were you a study participant in any study or research regarding hair relaxers?
Yes ☐ No ☐ Unknown ☐

If yes, identify the studies or research that You participated in and contact information of the administrator.

_____

_____

_____

VII. HEALTH INFORMATION

A. Vital Statistics

I. Current weight: _____

II. Current height: _____

III. Date of alleged diagnosed injury: _____

IV. Weight at time of diagnosed injury: _____

V. Highest weight at any time: _____

B. Pregnancies

I. Have you ever been pregnant?

☐ Yes ☐ No

Number of pregnancies: _____

II. If you have children, please state the following for EACH child:

Name	Address	Date of Birth

III. Did you give birth to your first child after age 30? Yes ☐ No ☐ N/A ☐

C. Menstrual History

I. Age at time of first period (menses): _____Age at time of last period (menses): _____

II. Are/were your menstrual cycles regular? Yes ☐ No ☐ Unsure ☐

If yes, or unsure, average length of cycle: _____

If yes, or unsure, average length of period: _____

III. Did you ever experience any abnormal menstruation (including irregular periods, painful periods, or absence of periods)? Yes ☐ No☐ Unsure ☐

If your answer is "Yes," or "Unsure," give the approximate dates and a description of each problem.

_____

_____

IV. If your answer is to Question 3. is "Yes," did you seek medical treatment or advice for any condition described in your answer to Question 3. above?
Yes ☐ No ☐

If your answer is yes, or, if you are unsure, state the name and address of the HEALTHCARE PROVIDER consulted, and the types of any such treatment(s) given by that provider.

Name	Address	Treatment(s)	Date(s) of Treatment(s)

D. Menopausal History

I. Are you menopausal, perimenopausal or postmenopausal? Yes ☐ No ☐ Unknown ☐

If yes, age at menopause: _____

E. Medical History

I. For EACH year, beginning ten (10) years prior to your alleged injury diagnosis to the present, who was your gynecological provider.

Doctor: _____

Office: _____

Year: _____

II. For EACH year beginning ten (10) years prior to your alleged injury diagnosis to the present, if you are alleging an injury to your breast such as breast cancer, who did you see for any mammogram?

Office: _____

Year: _____

III. If you know, have you ever been diagnosed with or experienced any of the following?

Condition	**Yes/No**	**Date of Diagnosis**	**Diagnosing Healthcare Provider including Location – State and City [if known]**
Adenomyosis			
Breast cancer			
Breast Lesions			
Congenital retinoblastoma			
Dense breast tissue			
Disorders of the reproductive tract			
Endometrial hyperplasia			
Endometriosis			
Gestational diabetes			
High blood pressure			
High cholesterol			
High estrogen levels			
Infertility			
Inflammatory Pelvic Disease			
Irregular vaginal bleeding			
Lobular carcinoma in situ (LCIS) of the breast			
Loeys-Dietz syndrome			
Lynch syndrome			
MUTYH-associated polyposis			
Obesity/overweight			

Condition	Yes/No	Date of Diagnosis	Diagnosing Healthcare Provider including Location – State and City [if known]
Osteopenia or osteoporosis			
Other cancer (please specify):			
Ovarian cancer or tumors			
Ovarian cysts			
Polycystic ovaries and/or Polycystic Ovarian Syndrome (PCOS)			
Rectal bleeding			
Type I diabetes mellitus			
Type II diabetes mellitus			
Uterine fibroids			

IV. Has any HEALTHCARE PROVIDER told you or your representative that you are at an increased risk for developing any type of cancer?

Yes ☐ No ☐ Unsure ☐

If yes, or unsure, state:

Name, current address, and telephone number of the HEALTHCARE

PROVIDER:_____

Date the statement was made: _____

Reason given, if any, for your increased risk of cancer: _____

Type of cancer, if any, for which you were told are at increased risk: _____

F. Other Risk Factors

I. If you are claiming as an alleged injury from your use of HAIR RELAXER PRODUCTS uterine or ovarian cancer, please state whether any of your biological family members (including your parents, siblings,

children, grandchildren, grandparents**),** living or deceased, been diagnosed with uterine, colon, or ovarian cancer. Yes ☐ No ☐ Unknown ☐

If yes, for each family member state:

Relative's Name	Relation to You	Relative's City and State [if known]	Type(s) of Cancer/Medical Condition	Relative Living or Deceased

G. Hormone Replacement Therapy

I. Have you ever undergone hormone replacement therapy? Yes ☐ No ☐

If yes, for each therapy state:

Therapy	Date(s) of Therapy	Prescriber (including address and phone number)	Administering HCP (including address and phone number)	Side-Effects You Experienced

H. Fertility Treatment

I. Have you ever undergone fertility treatment? Yes ☐ No ☐

If yes, for each treatment state:

Therapy	Date(s) of Therapy	Prescriber (including address and phone number)	Administering HCP (including address and phone number)	Side-Effects You Experienced

I. Genetic Testing

I. Have you been genetically tested for any of the for any of the following genetic mutations:

BRCA1 and BRCA2 Yes ☐ No ☐

If yes, state:

Name of the testing laboratory(ies): _____

Date(s) of testing: _____

Genes tested: _____

II. Has any HEALTHCARE PROVIDER recommended that you undergo genetic testing and/or genetic counseling? Yes ☐ No ☐

If yes, identify the HEALTHCARE PROVIDER that recommended you undergo genetic testing and/or genetic counseling, their specialty, current address, and the date he/she made the recommendation to you.

_____

_____

J. Toxicology

I. Have you ever taken tamoxifen? Yes ☐ No☐

If yes, state when you took tamoxifen, and who prescribed it to you, including the individual's address and phone number.

_____

K. Prescription Medications

I. Are there prescription medications that you took more than three (3) times at any time beginning one (1) year prior to your alleged injury diagnosis to the present? Yes ☐ No ☐

If yes, please provide the following for EACH prescription medication:

Medication	Prescriber	Pharmacy	Dates Taken

L. Have you ever participated in any clinical trials or taken any experimental medications? Yes ☐ No ☐ Unsure ☐

If yes, or unsure, please provide the name of medication or medical device, for what condition you took such medication or used such device, the dates of the clinical trial, who conducted the clinical trial and where the trial took place.

_____

_____

M. For each of the below products, if you have used them more than four (4) times a year at any time since the year before your alleged injury, please state that below and provide the brand, dates of use, and frequency of use for each product:

Product	Yes/No	Brand	Date(s) of Use	Frequency of Use
Anti-frizz/polish/ Brazilian Blowout/Keratin				
Hair Dye				
Hair-Smoothing Products				
Pomade				

VIII. FACT WITNESSES

A. Non- HEALTHCARE PROVIDERS

I. Identify all persons whom you believe possess information about your alleged injury, current medical condition, or lawsuit, other than your HEALTHCARE PROVIDER:

Name	**Location – State, City and Address [if known]**	**Relationship to You**	**Information**

IX. DOCUMENT REQUESTS

Please state which of the following DOCUMENTS you have in your possession, custody or control. If you do not have the following DOCUMENTS but know they exist in the possession of others, state who has possession of the DOCUMENTS. Produce all DOCUMENTS in your possession (including writings on paper or in electronic form) and signed authorizations and attach a copy of them to this PFS. For each document request listed below, unless otherwise stated in the request, the Relevant Time Period is defined above (i.e., ten (10) years prior to the injury). As it relates to any request for social media you are required to disclose the locations of these documents and You have a duty to preserve stored data and social media, but a production shall occur (if any) if your case has been designated for Phase II Discovery (e.g., your case is included in a bellwether selection pool). However, representative photographs of how you wore your hair for the ten (10) years prior to your injury should be produced with this PFS.

A. DOCUMENTS you reviewed to prepare your answers to this Plaintiff Fact Sheet.

Yes ☐ No ☐

Your attorney may withhold some DOCUMENTS on claims of attorney-client privilege or work product protection and, if so, provide a privilege log.

B. Medical records or other DOCUMENTS related to the use of HAIR RELAXER PRODUCTS.

Yes ☐ No ☐

C. If your alleged injury is a form of cancer, medical records or other DOCUMENTS relating to your diagnosis and/or treatment for any cancer for any time.

Yes ☐ No ☐

D. DOCUMENTS reflecting any genetic testing or counseling.

Yes ☐ No ☐

E. If your alleged injury is a form of cancer, pathology reports and results of biopsies performed on you.

Yes ☐ No ☐

Plaintiffs or their counsel must maintain the slides and/or specimens requested in this subpart, or send a preservation notice, copying Defendants, to the healthcare facility where these items are maintained

F. If your alleged injury is a form of cancer, DOCUMENTS identifying all chemotherapy agents that you have used.

Yes ☐ No ☐

G. DOCUMENTS relating to any workers' compensation, social security or other disability proceeding at any time within the last ten (10) years.

Yes ☐ No ☐

H. Instructions, product warnings, labels package inserts, handouts or other materials that you were provided or obtained in connection with your use of HAIR RELAXER PRODUCTS.

Yes ☐ No ☐

I. Advertisements, social media posts, blog posts, or promotions for HAIR RELAXER PRODUCTS.

Yes ☐ No ☐

J. Articles or posts discussing HAIR RELAXER PRODUCTS.

Yes ☐ No ☐

K. Any packaging, container, box, or label for HAIR RELAXER PRODUCTS that you were provided or obtained in connection with your use of HAIR RELAXER PRODUCTS.

Yes ☐ No ☐

Plaintiffs or their counsel must maintain the originals of these items.

L. DOCUMENTS that mention HAIR RELAXER PRODUCTS or any alleged health risks relating to HAIR RELAXER PRODUCTS.

Yes ☐ No ☐

Your attorney may withhold some legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance on claims of attorney-client privilege or work product protection and, if so, provide a privilege log.

M. Communications or correspondence between You and any representative of any of the defendants.

Yes ☐ No ☐

N. Journals or diaries at any time for the past ten (10) years relating to the use of HAIR RELAXER PRODUCTS or your treatment for any disease, condition or symptom referenced above, that are related to your alleged injury.

Yes ☐ No ☐

O. Photographs, videos, social media or internet posts to or through any site including cloud storage (including but not limited to Google drive and iCloud), websites, social networks (including but not limited X/Twitter, Facebook, Instagram, Snapchat, TikTok, MySpace, LinkedIn, dating websites, or "blogs"), chat rooms, or internet forums relating to your hairstyle or your use of HAIR RELAXER PRODUCTS that you have in your possession, custody or control.

Yes ☐ No☐

Please upload representative photographs of how you wore your hair for the ten years prior to your injury.

P. Photographs, videos, social media or internet posts to or through any site including cloud storage (including but not limited to Google drive and iCloud), websites, social networks (including X/Twitter, Facebook, Instagram, Snapchat, TikTok, MySpace, LinkedIn, dating websites, or "blogs"), chat rooms, or internet forums

relating to your claimed injuries that you have in your possession, custody or control.

Yes ☐ No ☐

Q. Photographs, videos, social media or internet posts to or through any site including cloud storage (including but not limited to Google drive and iCloud), websites, social networks (including X/Twitter, Facebook, Instagram, Snapchat, TikTok, MySpace, LinkedIn, dating websites, or "blogs"), chat rooms, or internet forums relating to your participation in this litigation that you have in your possession, custody or control.

Yes ☐ No ☐

Your attorney may withhold some legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance on claims of attorney-client privilege or work product protection and, if so, provide a privilege log.

R. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the five (5) years preceding the injury you allege to be caused by HAIR RELAXER PRODUCTS and every year thereafter, or W-2s for each of the five (5) years preceding the injury you allege to be caused by HAIR RELAXER PRODUCTS and every year thereafter.

Yes ☐ No ☐

S. If you claim any medical expenses, bills or invoices from any HEALTHCARE PROVIDER.

Yes ☐ No ☐

T. Records of any other expenses allegedly incurred as a result of your alleged injury.

Yes ☐ No ☐

U. If you are suing in a representative capacity, letters testamentary or letters of administration.

Yes ☐ No ☐

V. If you are suing in a representative capacity on behalf of a deceased person, the decedent's death certificate.

Yes ☐ No ☐

W. If you are suing in a representative capacity on behalf of a deceased person, the decedent's autopsy report.

Yes ☐ No ☐

X. Signed authorizations in the forms attached hereto.

Yes ☐ No ☐

X. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the DOCUMENTS requested in Part XI of this Plaintiff Fact Sheet to the extent that such DOCUMENTS are in my possession or in the possession of my lawyers, and that I have supplied the Authorizations attached to this declaration.

_____ _____

Signature Date

XI. AUTHORIZATIONS

See Attached Exhibit A.

AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____[Plaintiff/Injured Party Name]. whether created before or after the date of signature. Records requested may include, but are not limited to:

> all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____] (date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original employment records. Please take all steps that are necessary to preserve the employment records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in *In Re Hair Relaxer*, MDL No. 3060 (N.D. Il.), including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE INSURANCE INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing insurance information, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name],** whether created before or after the date of signature. Records requested may include, but are not limited to:

> applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original insurance records. Please take all steps that are necessary to preserve the insurance records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all medical records, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested include, but are not limited to:

> all medical records, physician's records, surgeon's records, pathology/cytology reports, pathology/cytology specimens, slides, wet tissue, tissue blocks, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, prescription profile records, prescription slips, medication records, orders for medication, payment records, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, orders for medications, therapists' notes, social worker's records, insurance records, treatment pre-certifications, consent for treatment, statements of account, itemized bills, payment records invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original medical records, radiology, pathology/cytology slides, tissue/cell blocks, and any recut slides that are in your possession, as an expert may need to examine these slides and blocks in the future. Please take all steps that are necessary to preserve the medical records, radiology films, slides and blocks, and any recut slides that remain in your possession.

This authorization also includes the authority to permit agents or designees of **BrownGreer/MRC** to inspect and copy any and all such records.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE PSYCHIATRIC RECORDS AND PSYCHOTHERAPY NOTES INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all psychiatric records and psychotherapy notes records, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested may include, but are not limited to:

> complete copies of all psychiatric records and psychotherapy notes reports, therapist's notes, social worker's records, all medical records, physicians' records, surgeons' records, pathology/cytology reports, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, records of drug abuse and alcohol abuse, physicals and histories, nurses' notes, correspondence, insurance records, consent for treatment, statements of account, itemized bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning the physical or mental condition of this patient, or documents containing information regarding amendment of protected health information (PHI) in the medical records. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____] (date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original medical records, radiology, pathology/cytology slides, tissue/cell blocks, and any recut slides that are in your possession, as an expert may need to examine these slides and blocks in the future. Please take all steps that are necessary to preserve the medical records, radiology films, slides and blocks, and any recut slides that remain in your possession.

I do not authorize any ex parte verbal/oral communication concerning the subject mater of this authorization.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose my PHI, including psychiatric records and psychotherapy notes records and information, to **BrownGreer/MRC**. I further understand that records pertaining to psychiatric records and psychotherapy notes information may be specifically protected by federal and/or state regulations; by signing this authorization I am allowing the disclosure of any psychiatric records and psychotherapy notes information held by the entity identified above.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all psychiatric records and psychotherapy notes, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested may include, but are not limited to:

> complete copies of all psychiatric records and psychotherapy notes as defined by HIPAA 45 C.F.R. 164.501: psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original medical records, radiology, pathology/cytology slides, tissue/cell blocks, and any recut slides that are in your possession, as an expert may need to examine these slides and blocks in the future. Please take all steps that are necessary to preserve the medical records, radiology films, slides and blocks, and any recut slides that remain in your possession.

I do not authorize any ex parte verbal/oral communication concerning the subject mater of this authorization.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose my PHI, including psychiatric records and psychotherapy notes, to **BrownGreer/MRC**. I further understand that records pertaining to the psychiatric records and psychotherapy notes may be specifically protected by federal and/or state regulations; by signing this authorization I am allowing the disclosure of any psychiatric records and psychotherapy notes held by the entity identified above.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address

AUTHORIZATION TO DISCLOSE TAX RETURNS INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing Tax information, regarding _____**[Plaintiff/Injured Party Name],** whether created before or after the date of signature. Records requested may include, but are not limited to:

> all tax returns, attachments to tax returns, forms, schedules, correspondence, and any statements, communications, reports, questionnaires, and records submitted, and any and all other documents and writings of any kind for the time period of 10 years prior to [_____](date of alleged injury) to the present.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above firms. A copy of this authorization may be used in place of and with the same force and effect as the original. This authorization expires one year after it is signed.

_____
Injured Party/Plaintiff or Personal Representative

_____
Date

_____
Name

_____
Former/Alias/Maiden Name

_____
Date of Birth Date of Death

_____
Social Security Number

_____
Address

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

To:

For informational purposes pertaining to civil litigation, I authorize and request the Custodian of Records at the above-named entity to disclose to **BrownGreer/MRC** any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding **_____[Plaintiff/Injured Party Name]**, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of 10 years prior to [_____](date of alleged injury) to the present.

Because this litigation is ongoing, it is essential that you preserve the original workers' compensation records. Please take all steps that are necessary to preserve the workers' compensation records that remain in your possession.

Unless revoked in writing, this authorization shall be valid for the period of litigation in **In Re Hair Relaxer, MDL No. 3060 (N.D. Il.)**, including any and all transfers and the exhaustion of all appeals. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, but shall provide a copy of the revocation to BrownGreer/MRC, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients on the terms and conditions set forth in the case management order(s) governing the subject lawsuit, and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**

I have read the foregoing Authorization and understand that it will permit the entity identified above to disclose PHI to **BrownGreer/MRC**.

Injured Party/Plaintiff or Personal Representative

Date

Name

Former/Alias/Maiden Name

Date of Birth Date of Death

Social Security Number

Address