AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please fill out the information below and return this form along with the Claim Form and Verification of Income Form.

Participant Name:

_____

Date of Birth (MM/DD/YYY):

_____

Participant Address: _____

I, _____, hereby authorize TASC and its attorneys to release and transfer any and all information, including private medical information and substance abuse information, ordinarily protected from disclosure under the Private Health Services Act (42 U.S.C. § 290dd- 2(a), 42.C.F.R. Part 2), or the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936) (HIPAA), in its possession or control to Atticus Administration, the settlement administrator. I understand and authorize Atticus to disclose and share this information with attorneys for the putative class in *Briggs v. TASC* (D. Ariz. 2018). I further understand that this information may be used by Atticus and class counsel to assess whether I am a member of the class.

This authorization will expire upon conclusion of the legal proceedings for which I am granting this authorization, unless otherwise specified.

I understand that I retain the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present the signed and dated revocation to Atticus. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____

Date Signature