NFL CONCUSSION SETTLEMENT

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION
No. 2:12-md-02323 (E.D. Pa.)

MONETARY AWARD CLAIM PACKAGE HIPAA AUTHORIZATION FORM

You must complete and sign this Form if you are a **Retired NFL Football Player** or the **Representative Claimant** of a Retired NFL Football Player and want to apply for a Monetary Award. This Form authorizes the use and disclosure of "Protected Health Information" as that term is defined in 45 C.F.R. § 160.103, relating to the processing of your claim in the NFL Concussion Settlement Program. Protected Health Information includes, but is not limited to, information regarding the Retired NFL Football Player's medical care, treatment, physical or mental condition, and medical expenses.

I. RETIRED NFL FOOTBALL PLAYER INFORMATION

Settlement Program ID				
Player Name	First	M.I.	Last	Suffix

Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) **of Retired NFL Football Player** (if known)

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or

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Date of Birth of Retired NFL Football Player

|_|_|/|_|_|/|_|_|_|_|
(Month/Day/Year)

II. ENTITIES AUTHORIZED TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing and submitting this Form, I authorize the use and disclosure of all Protected Health Information regarding my (or the Retired NFL Football Player's, if signed by a Representative Claimant) medical care, treatment, physical or mental condition, and medical expenses relating to my claim in the *In re: National Football League Players' Concussion Injury Litigation* Settlement program, as follows: (1) by the Claims Administrator, Special Masters, BAP Administrator, Lien Resolution Administrator, designated Qualified BAP Providers, Qualified BAP Pharmacy Vendors, Qualified MAF Physicians, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties and the NFL Parties (which, in turn, may share the Protected Health Information with the NFL Parties' insurers or reinsurers) for use and/or disclosure with one another in the performance of their functions and duties pursuant to the Settlement Agreement; (2) by the Lien Resolution Administrator for use and/or disclosure to the holders of any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type, including all Governmental Payors (such as the Medicare Program, any state Medicaid Program, the Department of Veterans Affairs, Tricare, Indian Health Services, and their respective contractors), Medicare Part C or Part D Programs, private health care providers, health plans, and health insurers, and any contractors or recovery agents of the foregoing persons and entities (collectively, "Lienholders"), for the purpose of identifying and resolving any potential Liens in connection with any Monetary Award that I may receive; and (3) by the Lienholders for disclosure to the Lien Resolution Administrator and Claims Administrator for the purpose of identifying and resolving any potential Liens in connection with any Monetary Award that I may receive.

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III. AUTHORIZATION

By signing below, I acknowledge and understand all of the following:

1.	I have the right to revoke this authorization at any time. If I wish to revoke the authorization, I must do so in writing and must provide my written revocation to the Claims Administrator. The written revocation must be signed and dated. The revocation will not apply to any disclosures that already have been made in reliance on this authorization prior to the date upon which the Claims Administrator receives my written revocation.
2.	My authorization of the disclosure of the subject Retired NFL Football Player's Protected Health Information is voluntary, which means I can refuse to sign this Form. I do not need to sign this Form to obtain health treatment from any medical provider or to enroll in or be eligible for any health plan benefits. However, I recognize that if I do not sign this Form and submit it to the Claims Administrator, my Claim Package will be incomplete under the terms of the Settlement Agreement and will not be processed.
3.	Any Protected Health Information or other information released to the Claims Administrator, Special Masters, BAP Administrator, Lien Resolution Administrator, Qualified BAP Providers, Qualified BAP Pharmacy Vendors, Qualified MAF Physicians, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties and the NFL Parties (including the NFL Parties' insurers or reinsurers) may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
4.	My Protected Health Information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome ("AIDS"), or human immunodeficiency virus ("HIV"), behavioral or mental health services and treatment for alcohol and drug abuse.
5.	This Form is valid from the date of my signature in Section IV until the date that the Claims Administrator performs the last act to process the claim for a Monetary Award that I submitted with this Form.
6.	I have a right to receive and retain a copy of this Form.
7.	Any photostatic copy of this Form shall have the same authority as the original, and may be substituted in its place.

IV. SIGNATURE

The Retired NFL Football Player or Representative Claimant of the Retired NFL Football Player named in Section I must sign and date this Form below. **By signing below, I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that all information provided in this HIPAA Authorization Form is true and correct to the best of my knowledge, information and belief.**

Signature			**Date**	__/__/____ (Month/Day/Year)
Printed Name	First	M.I.	Last	Suffix
If you are signing this Form as a Representative Claimant, describe your relationship to the Retired NFL Football Player and your authority to act on his behalf:				

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V. HOW TO SUBMIT THIS FORM

You may submit this Form in one of two ways:

By U.S. Mail:	NFL Class Action Settlement Claims Administrator P.O. Box 25369 Richmond, VA 23260
By Delivery:	NFL Class Action Settlement c/o BrownGreer PLC 250 Rocketts Way Richmond, VA 23231