Healthcare Lien and Subrogation Authorization

Authorization for Use and Disclosure of Protected Health Information Pursuant to HIPAA 45 C.F.R. §164.508

To: _____ (Insurer or Other Disclosing Party)

Re: _____ (Plaintiff/Beneficiary/Claimant)

I hereby authorize the above-noted disclosing party and/or their agents to release, upon request, certain protected health information to DevaCurl Products Settlement Administrator or its designated Lien Lawyers ("THE LIEN LAWYERS") as authorized by the Court's Preliminary Approval Order in the case of *In re Deva Concepts Products Liability Litigation* in the United States District Court for the Southern District of New York, Case No. 20-cv-01234 for the purpose of disclosure and resolution of healthcare and medical liens. The health plan is hereby authorized to disclose: all enrollment information, medical records and payment information (including itemizations of said payments and supporting information such as ICD-9/10 codes) related to the injury/illness. This authorization covers the release of all past, present, and future records.

I have had full opportunity to read and consider the contents of this document and I understand that my health plan may not condition my enrollment, my eligibility, my treatment, or payment for such services on whether this authorization is signed.

I further authorize THE LIEN LAWYERS to **make any changes, waivers, disputes, and take any other necessary actions to fully resolve the lien on my case**. This notice serves as proof of THE LIEN LAWYERS' representation of the undersigned.

REVOCATION: I understand that I may refuse to sign this authorization and that I may revoke it at any time, but I must do so in writing to the above-noted disclosing party. The revocation will not be effective to the extent that information has already been disclosed pursuant to this authorization. I understand that I have the right to receive a copy of this authorization after it is signed.

RE-DISCLOSURE: I understand that the persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

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

Person(s)/Entity Authorized to Receive Information:

The Lien Lawyers
2500 Gulf Tower
Suite 125
Pittsburgh, PA 15219-1918

Injured Person's Information:

Injured Person's Name (as shown on insurance card):

_____

I authorize the disclosure described herein. I have read and understand this authorization. I am the beneficiary listed on this authorization or am authorized to act on behalf of the beneficiary as the beneficiary's personal representative.

Expiration: This Healthcare Lien and Subrogation Authorization expires upon resolution of the matter for which it was intended, or, if revoked by me at an earlier time.

_____ _____

Signature Printed Name

_____ _____

Relationship to injured person Date Signed (mm/dd/yyyy)