



**IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA**

**IN RE: WATER CONTAMINATION LITIGATION CIVIL ACTION NO. 16-C-6000**

**THIS DOCUMENT APPLIES TO ALL CASES**

**AMENDED STIPULATED PROTECTIVE ORDER AND SHARING AGREEMENT**

IT IS HEREBY STIPULATED and agreed to by and between counsel for the parties that the terms and conditions of this Amended Stipulated Protective Order and Sharing Agreement shall be legally enforceable and binding.

**I. PROTECTIVE ORDER**

During the course of this Action, the Plaintiffs and/or others may be required to produce or disclose information they consider to be confidential, including but not limited to information pertaining to their:

- (i) Medical and Pharmacy Records,
- (ii) Social Security Records,
- (iii) Employment Records,
- (iv) Business and Financial Records,
- (v) Tax Records,
- (vi) Workers' Compensation Records,
- (vii) Medicare/Medicaid Records, and/or
- (viii) Education Records.

Accordingly, pursuant to the provisions of Rule 26(c) of the West Virginia Rules of Civil Procedure, the Court hereby ORDERS:

1. The terms hereafter defined in the following sub-paragraphs shall have the meanings designated herein. Defined terms may be used in the singular or the plural:

1.1 “Confidential Information” means any information obtained by the Defendants using any Authorization executed by any Plaintiff, including, but not necessarily limited to:

- (i) Medical Records,
- (ii) Social Security Records,
- (iii) Employment Records,
- (iv) Business and Financial Records,
- (v) Tax Records,
- (vi) Workers’ Compensation Records,
- (vii) Medicare/Medicaid Records, and/or
- (viii) Education Records.

1.2 “Authorization” means the attached instruments, which are incorporated herein by reference, that authorize Defendants’ attorneys to see or copy any documents, x-rays or records regarding any Plaintiff’s medical conditions, treatment, medical bills, and/or damages, as well as any Plaintiff’s social security, employment, business, financial, tax, and education records.

1.3 “Termination” means the dismissal of this Action or entry of final judgment and expiration of all periods of appeal.

2. All “Confidential Information” shall be used solely for the purposes of this Action and shall not directly or indirectly, in whole or in part, be revealed or disclosed or made available for inspection or copying, except to:

2.1 The Court, its personnel, and any jury impaneled along with any other court having jurisdiction over discovery procedures in this Action;

2.2 Court reporters, videographers, or typists transcribing or recording testimony in this Action, and any independent reproduction service utilized solely for purposes of this Action;

2.3 Attorneys employed by the Defendants and support staff of those attorneys who assist with the preparation or trial of this Action, including but not limited to law clerks, legal assistants, secretaries, and clerks;

2.4 Consultants, insurance adjustors, experts and their employees Defendants believe are needed for consultation for purposes of defending this Action, or persons who have been designated, or are being considered for designation as, expert witnesses or consultants, including the support staff of those experts or consultants;

2.5 Counsel for Plaintiffs and Defendants may disclose records to each other; and,

2.6 Defendants' counsel may disclose "Confidential Information" or summaries thereof (such as medical record summaries) to their clients or their clients' representatives, provided that their clients or clients' representatives agree to be bound by the instant Protective Order. If such summaries are created for defense counsels' clients, Plaintiffs recognize that any such summaries would be subject to the attorney-client and/or work product doctrine and would not be discoverable.

3. If any party or attorney wishes to file or to use as an exhibit or as evidence at a hearing or trial any Confidential Information or material, s/he must provide reasonable notice to the party who produced the document or material. The parties and/or attorneys shall then attempt to resolve the matter of continued confidentiality by either (a) removing the "Confidential" marking or (b) creating a mutually acceptable redacted version that suffices for purposes of the case. If an amicable resolution proves unsuccessful, the parties and/or attorneys may present the issue to the

court for resolution. The proponent of continued confidentiality will have the burden of persuasion that the document or material should be withheld from the public record.

4. No “Confidential Information” may be revealed or disclosed to those individuals identified in paragraphs 2.4 and 2.6, directly or indirectly, in whole or in part, until the individual has been given a copy of this Order and has signed an acknowledgement of receipt in the form attached.

5. Copies of all “Confidential Information” obtained by Defendants pursuant to Authorizations must be furnished to Plaintiffs’ counsel no later than fourteen (14) days after its receipt or seven (7) days before its use in deposition or trial.

6. The cost of obtaining and making copies of all “Confidential Information” as described above must be made per the Sharing Agreement below.

7. All “Confidential Information” records must be marked with a common production number to be used by both Plaintiffs and Defendants.

8. Defense Counsel shall maintain a log of all persons to whom Defense Counsel have provided copies of any “Confidential Information.” Copies of these logs shall be made available to Plaintiffs upon “Termination” of this Action. Because consultants may be retained by parties in this litigation and such individuals may be given access to the materials described herein, parties utilizing such experts may redact those individuals’ name(s) under a claim of privilege from any such logs prepared and maintained by Defendants.

9. All “Confidential Information” shall be returned to Plaintiffs’ counsel or destroyed within thirty (30) days of “Termination” of this Action.

10. This Order shall not be construed as waiver by the parties of any objection which might be raised as to the admissibility of any evidentiary material. This Order shall be without

prejudice to the rights of any person to oppose production of any information on any proper ground.

11. Insofar as the provisions of this Order restrict the use or communication of any document or information hereunder, this Order shall continue to be binding after the “Termination” of this Action and the Court shall retain jurisdiction to enforce this Order over all persons and parties bound by this Order for a period of six (6) months.

The Court hereby ORDERS that each Plaintiff provide executed copies of the “Authorizations” attached hereto and further ORDERS that all “Confidential Information” obtained pursuant to these “Authorizations” be handled in accordance with the restrictions set forth above.

## **II. SHARING AGREEMENT**

Certain of the “Authorizations” in this matter allow records requested by the Defendants to be produced to Jackson Kelly PLLC. Defendants did not request one authorization from every Plaintiff (or other person for whom records are sought) for each of the Defendants in this matter. Accordingly, it is the Court’s understanding that the parties herein have agreed to be bound as follows concerning the collection of and payment for records collected with Plaintiffs’ Authorizations:

1. The parties agree that Jackson Kelly PLLC will use the Authorizations executed by the Plaintiffs and/or others to obtain records concerning the Plaintiffs. Jackson Kelly PLLC will provide a copy (see paragraph 6 below) of each request made for records using an Authorization in this matter to Co-Lead Counsel and Liaison Counsel for Plaintiffs, Anthony Majestro, or his designee.

2. Once records are obtained by Jackson Kelly, Plaintiffs agree that Jackson Kelly may provide all records received to all counsel of record who are signatories to this agreement (see paragraph 6 below).

3. The parties, through their counsel of record, agree that they will all share equally in the total cost involved in collecting and distributing each set of records.

4. For purposes of sharing costs for the collection of records, plaintiffs collectively shall pay for one share of the cost of collecting these records and each defendant (or related group of defendants) represented by the same counsel shall pay for one share of the costs of obtaining the records.

5. Jackson Kelly will provide copies of invoices justifying the actual incurred costs for records collection and will invoice all counsel who are part of this sharing agreement as invoices are received. Counsel participating in this sharing agreement hereby agree to pay all Jackson Kelly invoices upon receipt and in no event shall such payment take longer than thirty (30) days. Payments not received within thirty (30) days will result in a denial of access to future records collected until payment is received.

6. Jackson Kelly will upload and host an online database at its expense wherein all records can be accessed and downloaded by those agreeing to this Protective Order and Sharing Agreement.

7. The parties agree to work through any disputes concerning the collection of, or payment for, any records collected with the Authorizations in this matter in good faith before seeking involvement of the Court or engaging in motion practice.

It is so **ORDERED**.

**ENTER:** June 9, 2016.

/s/ Alan D. Moats  
Lead Presiding Judge  
Water Contamination Litigation

Prepared by:

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/s/ Thomas J. Hurney, Jr.  
Thomas J. Hurney, Jr. (WV Bar No. 1833)  
**JACKSON KELLY PLLC**  
P. O. Box 553  
Charleston, West Virginia 25322  
(304) 340-1000

*Counsel for West Virginia-American Water Company and  
Liaison Counsel for Defendants*

Agreed to by:

---

/s/ Anthony J. Majestro  
Anthony J. Majestro  
POWELL & MAJESTRO, PLLC  
405 Capitol Street, Supte P-1200  
Charleston, WV 25301  
(304) 356-2889

*Co-Lead Counsel and Liaison Counsel for Plaintiffs*

**ACKNOWLEDGEMENT OF RECEIPT OF  
PROTECTIVE ORDER AND SHARING AGREEMENT**

1. I have carefully read and understand the attached Protective Order and Sharing Agreement which was entered by a Presiding Judge of the Mass Litigation Panel sitting in the Circuit Court of Kanawha County, West Virginia in the action entitled In Re Water Contamination Litigation, Civil Action No. 16-C-6000.

2. Pursuant to the Protective Order and Sharing Agreement, I may be given access to “Confidential Information” and/or information marked “CONFIDENTIAL.” As a condition precedent of access to that information: (a) I agree that I shall be bound by and comply with all the terms of the Protective Order and Sharing Agreement, including those limiting disclosure and use of the information and (b) I submit to the jurisdiction of the West Virginia Mass Litigation Panel for the purpose of any proceedings relating to performance under, compliance with, or violation of the above-described Protective Order and Sharing Agreement.

3. I understand and agree that the obligation to protect all confidential information as set forth in this Protective Order and Sharing Agreement is enforceable against me.

4. I have executed this Acknowledgment on \_\_\_\_\_, 20\_\_\_\_, whereupon it becomes binding in accordance with its terms.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)



4. All pharmacy/prescription records, including DNC numbers and drug information handouts/monographs; and

5. All billing records, including all statements, itemized bills and records of billing to third party payers and payment or denial of benefits;

*All concerning:*

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's SSN: \_\_\_\_\_

**This Authorization excludes psychotherapy notes, which term has the meaning given it by the federal regulations at 42 C.F.R. § 164.501, and on the date of this Authorization is defined as notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the patient's medical record. This Authorization specifically authorizes the release or disclosure of all mental health, psychiatric and psychological records and documents other than psychotherapy notes, including inpatient, outpatient and emergency room treatment records, all clinical charts, reports, order sheets, progress notes, nurses' notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, correspondence, test results, statements, questionnaires and histories, records received by or from other physicians, pharmacy and prescription records, billing records and records of billing to third party payers and payment or denial of benefits. This Authorization also specifically authorizes the release or disclosure of records for the diagnosis or treatment of alcoholism or substance abuse and records relating to HIV/AIDS.**

The restrictions placed on the release of the records described above by state and federal laws and regulations are expressly waived.

This Authorization is valid until: Conclusion of this litigation.

Signature of the patient or patient's duly authorized representative:

\_\_\_\_\_

WITNESS: \_\_\_\_\_

Description of the authority of the patient's personal representative (if applicable):  
\_\_\_\_\_

Date: \_\_\_\_\_

**STATEMENT OF PATIENT RIGHTS:**

1. I understand that I may revoke this Authorization at any time by providing a signed and dated revocation in writing to the Disclosing Entity or Person identified above. This written revocation will take priority over this Authorization, except to the extent that the Disclosing Entity or Person has already disclosed health information prior to the receipt of my written revocation.
2. I understand that treatment, payment and other benefits may not be conditioned upon my signing of this Authorization.
3. I understand that health information disclosed pursuant to this Authorization may be redisclosed by the Receiving Entity without my knowledge or permission and the HIPAA Privacy Rule may no longer protect the disclosed health information.
4. I am entitled to receive a copy of this signed Authorization.

### Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

**NOTE:** Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at [www.ssa.gov/online/ssa-7050.pdf](http://www.ssa.gov/online/ssa-7050.pdf).

### How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (\*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

### PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, [www.socialsecurity.gov](http://www.socialsecurity.gov), or at your local Social Security office.

### PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at [www.socialsecurity.gov](http://www.socialsecurity.gov). Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

**Consent for Release of Information**

You must complete all required fields. We will not honor your request unless all required fields are completed. (\*signifies a required field).

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number
I authorize the Social Security Administration to release information or records about me to:		
*NAME OF PERSON OR ORGANIZATION: Jackson Kelly PLLC	*ADDRESS OF PERSON OR ORGANIZATION: P.O. Box 553	
Attn: L. Jill McIntyre	Charleston, WV 25322	

\*I want this information released because: I am in litigation and my records have been requested.  
We may charge a fee to release information for non-program purposes.

**\*Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1.  Social Security Number
2.  Current monthly Social Security benefit amount
3.  Current monthly Supplemental Security Income payment amount
4.  My benefit or payment amounts from date 01/01/2004 to date present
5.  My Medicare entitlement from date 01/01/2014 to date present
6.  Medical records from my claims folder(s) from date 09/01/2004 to date present

If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.

7.  Complete medical records from my claims folder(s)
8.  Other record(s) from my file (you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

\*Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

\*Address: \_\_\_\_\_

Relationship (if not the subject of the record): \_\_\_\_\_ \*Daytime Phone: \_\_\_\_\_

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness	2. Signature of witness
Address(Number and street, City, State, and Zip Code)	Address(Number and street, City, State, and Zip Code)

IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA  
IN RE: WATER CONTAMINATION LITIGATION    CIVIL ACTION NO. 16-C-6000

**AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS**

TO WHOM IT MAY CONCERN:

I, the undersigned, \_\_\_\_\_ do hereby authorize any individual or company to release (upon presentment of this authorization or any photostatic copy of the same) to any member of the law firm of Jackson Kelly PLLC (Receiving Entity) or to any designee thereof, or to bearer, any information, papers, documents and notes concerning my employment or application for employment, including, but not limited to, applications, dates of employment, attendance records, pay history, any and all unemployment records and entirety of any personnel file. I further authorize any recruiting agency, recruiter, executive search agency, employer consultation agency, staffing firm, employment agency or professional search consultant to release any information, papers, documents and notes concerning me, any employment for which I was considered, any search for employment on my behalf or any employment which I was a potential or actual candidate, including but not limited to applications, resumes, correspondence and entirety of any personnel file or similar file. This authorization also includes authority to copy any and all papers, records, etc. The Receiving Entity herein may distribute my records to any counsel in this litigation, upon payment to the Receiving Entity for the same, so long as my records are not disclosed outside of this litigation.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 2016.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

# Request for Copy of Tax Return

- ▶ **Do not sign this form unless all applicable lines have been completed.**
- ▶ **Request may be rejected if the form is incomplete or illegible.**
- ▶ **For more information about Form 4506, visit [www.irs.gov/form4506](http://www.irs.gov/form4506).**

**Tip.** You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return**, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at [IRS.gov](http://IRS.gov) and click on "Get a Tax Transcript..." or call 1-800-908-9946.

<b>1a</b> Name shown on tax return. If a joint return, enter the name shown first.	<b>1b</b> First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
<b>2a</b> If a joint return, enter spouse's name shown on tax return.	<b>2b</b> Second social security number or individual taxpayer identification number if joint tax return
<b>3</b> Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)	

**4** Previous address shown on the last return filed if different from line 3 (see instructions)

**5** If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.  
L. Jill McIntyre, Esq., Jackson Kelly PLLC, P. O. Box 553, Charleston, WV 25322 (304) 340-1018

**Caution:** If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

**6 Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ \_\_\_\_\_

**Note:** If the copies must be certified for court or administrative proceedings, check here

**7 Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

12/31/2014	12/31/2013	12/31/2012	12/31/2011

<b>8 Fee.</b> There is a \$50 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.	
<b>a</b> Cost for each return . . . . .	<b>\$ 50.00</b>
<b>b</b> Number of returns requested on line 7 . . . . .	
<b>c</b> Total cost. Multiply line 8a by line 8b . . . . .	<b>\$</b> _____

**9** If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here

**Caution:** Do not sign this form unless all applicable lines have been completed.

**Signature of taxpayer(s).** I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** For tax returns being sent to a third party, this form must be received within 120 days of the signature date.

**Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

<b>Sign Here</b>		Date	
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
		Date	

Section references are to the Internal Revenue Code unless otherwise noted.

## Future Developments

For the latest information about Form 4506 and its instructions, go to [www.irs.gov/form4506](http://www.irs.gov/form4506). Information about any recent developments affecting Form 4506, Form 4506-T and Form 4506T-EZ will be posted on that page.

## General Instructions

**Caution:** Do not sign this form unless all applicable lines have been completed.

**Purpose of form.** Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

**How long will it take?** It may take up to 75 calendar days for us to process your request.

**Tip.** Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of nonfiling, and records of account.

**Automated transcript request.** You can quickly request transcripts by using our automated self-help service tools. Please visit us at [IRS.gov](http://IRS.gov) and click on "Get a Tax Transcript..." or call 1-800-908-9946.

**Where to file.** Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

### Chart for individual returns (Form 1040 series)

#### If you filed an individual return and lived in:

#### Mail to:

Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address

Internal Revenue Service  
RAIVS Team  
Stop 6716 AUSC  
Austin, TX 73301

Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming

Internal Revenue Service  
RAIVS Team  
Stop 37106  
Fresno, CA 93888

Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia

Internal Revenue Service  
RAIVS Team  
Stop 6705 P-6  
Kansas City, MO  
64999

## Chart for all other returns

#### If you lived in or your business was in:

#### Mail to:

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address

Internal Revenue Service  
RAIVS Team  
P.O. Box 9941  
Mail Stop 6734  
Ogden, UT 84409

Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin

Internal Revenue Service  
RAIVS Team  
P.O. Box 145500  
Stop 2800 F  
Cincinnati, OH 45250

## Specific Instructions

**Line 1b.** Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

**Line 3.** Enter your current address. If you use a P.O. box, please include it on this line 3.

**Line 4.** Enter the address shown on the last return filed. If different from the address entered on line 3.

**Note:** If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

**Signature and date.** Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.



**CAUTION** You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

**Individuals.** Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

**Corporations.** Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

**Partnerships.** Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

**All others.** See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

**Note:** If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

**Documentation.** For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

**Signature by a representative.** A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

### Privacy Act and Paperwork Reduction Act

**Notice.** We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form, 10 min.; Preparing the form, 16 min.; and Copying, assembling, and sending the form to the IRS, 20 min.**

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service  
Tax Forms and Publications Division  
1111 Constitution Ave. NW, IR-6526  
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

**WV-ARI-001**  
Rev. 7/14**Authorization to Release Information**West Virginia  
State Tax  
Department

Name of Taxpayer \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Daytime Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

West Virginia Identification, SSN, FEIN, or Other \_\_\_\_\_

The above named taxpayer does hereby waive the confidentiality provisions of West Virginia Code §11-10-5d and/or §11-1A-23 to the following extent:

**1. Persons to whom information may be released:**

Name \_\_\_\_\_ Capacity \_\_\_\_\_

Address \_\_\_\_\_ Daytime Telephone \_\_\_\_\_

City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**2. Effective period of this waiver** Authorization terminates \_\_\_\_\_  
month day year Until my liability for the delinquent tax or taxes checked in paragraph 3, below, is satisfied. Other (explain) \_\_\_\_\_**3. Taxes and/or credits to which this waiver applies:**

	WV Code		WV Code
<input type="checkbox"/> Beer Barrel Tax	11-16	<input type="checkbox"/> Minimum Severance Tax on Coal	11-12B
<input type="checkbox"/> Business and Occupation Tax	11-13	<input type="checkbox"/> Motor Carrier Road Tax	11-14A
<input type="checkbox"/> Business Franchise Tax	11-23	<input type="checkbox"/> Personal Income Tax	11-21
<input type="checkbox"/> Business Registration Tax	11-12	<input type="checkbox"/> Property Taxes	
<input type="checkbox"/> Charitable Raffle Boards & Games	47-23	<input type="checkbox"/> Severance Tax	11-13A
<input type="checkbox"/> Consumer Sales and Service Tax	11-15	<input type="checkbox"/> Solid Waste Fee	20-5F
<input type="checkbox"/> Corporate License Tax	11-12C	<input type="checkbox"/> Soft Drink Tax	11-19
<input type="checkbox"/> Corporate Net Income Tax	11-24	<input type="checkbox"/> Strategic Research and Development Tax Credit	11-13R
<input type="checkbox"/> Economic Opportunity Tax Credit	11-13Q	<input type="checkbox"/> Telecommunications Tax	11-13B
<input type="checkbox"/> Employers Withholding Tax	11-10	<input type="checkbox"/> Tobacco Products Excise Tax	11-17
<input type="checkbox"/> Estate Tax	11-11	<input type="checkbox"/> Use Tax	11-15A
<input type="checkbox"/> Gasoline & Special Fuel Excise Tax	11-14	<input type="checkbox"/> Wine Liter Tax	60-8
<input type="checkbox"/> Health Care Provider Taxes	11-27	<input type="checkbox"/> All of the above applicable to the taxpayer	
<input type="checkbox"/> IFTA	11-14B	<input type="checkbox"/> Other Taxes (as listed below)	
<input type="checkbox"/> Manufacturing Investment Tax Credit	11-13S		

**4. Information to be released (describe specifically):**


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**5. Reason(s) why information is to be released:**

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This waiver will be effective only to the extent explained above and any other release of information is not permitted without additional authorization. Additionally, information will be released only to the extent the Tax Commissioner believes disclosure is necessary to comply with this Authorization to disclose information, and will not be disclosed to the extent the Tax Commissioner determines that disclosure would seriously impair administration of this State's tax laws.

This authorization must be signed by the taxpayer, or taxpayer's authorized representative, and the signature of the person signing the authorization must be notarized. Documentation of fiduciary relationships (e.g. Guardianship, POA, Trustee, Executrix) must be attached. Please note that original signatures are required. Faxed, photocopied or stamped signatures are unacceptable.

Authorization is for:

- release of personal income tax return(s); if jointly filed personal income tax return is requested, the authorization must be signed by either the husband or the wife.
- release of a return filed by a business that is a sole proprietorship, the authorization must be signed by the owner of the business or by an employee of the business, or other person, who is authorized to sign the authorization.
- a corporation, the authorization must be signed by its president, vice president, treasurer, assistant treasurer, chief accounting officer or other person duly authorized to sign the authorization.
- release of a return filed by a partnership, as defined for federal income tax purposes, the authorization must be signed by the managing partner, or tax matters partner, or any other partner or employee of the partnership authorized to sign the authorization.
- release of a return filed by a limited liability company, the authorization must be signed by the managing member, tax matters member, or any other member or employee of the limited liability company authorized to sign the authorization.
- a return filed by an estate or trust, the authorization must be signed by the executor or executrix of the estate, or the trustee of the trust.
- for information other than a tax return, the authorization must be signed by a person who could authorize release of taxpayer's tax return.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Capacity

\_\_\_\_\_  
Date

State of \_\_\_\_\_

County of \_\_\_\_\_, to-wit,

This day appeared before me, the undersigned notary public, \_\_\_\_\_ who  
acknowledge under oath the signature above. Print Taxpayer's Name

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Date

My commission expires \_\_\_\_\_

**“Consent to Release”**  
**Liability Insurance (Including Self-Insurance), No-Fault Insurance,**  
**or Workers’ Compensation**

**Where to find Information on “Consent to Release” vs. “Proof of Representation”**

Please refer to the PowerPoint document on this website titled: “Rules and Model Language for ‘Proof of Representation’ vs. ‘Consent to Release’ for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers’ Compensation” for detailed information on

- **When to use a “consent to release” document vs. a “proof of representation” document,**
- Appropriate content for both documents,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary’s guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary’s representative signs a “consent to release” document on the beneficiary’s behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers’ compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers’ or workers’ compensation.

**General**

A “consent to release” document is used by an individual or entity who does not represent the Medicare beneficiary but is requesting information regarding the beneficiary’s conditional payment information. A “consent to release” does not authorize the individual or entity to act on behalf of the beneficiary or make decisions on behalf of the beneficiary.

**Model Language**

See attached. Use of the model language is not required, but any documentation submitted as a “Consent to Release” must include the information the model language requests.

**Where to Submit a “ Consent to Release” document:**

**Liability Insurance, No-Fault Insurance, Workers’ Compensation:**

*NGHP*  
*PO Box 138832*  
Oklahoma City, OK 73113  
**Fax: (405) 869-3309**

MODEL LANGUAGE

**CONSENT TO RELEASE**

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I, \_\_\_\_\_ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

**CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:**

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

Insurance Company       Workers' Compensation Carrier       Other \_\_\_\_\_  
(Explain)

Name of entity: \_\_\_\_\_

Contact for above entity: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone:

**CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION**

(The period you check will run from when you sign and date below.):

One Year       Two Years       Other \_\_\_\_\_  
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

**MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:**

Beneficiary Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit <http://go.cms.gov/cobro> for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_

**IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA**  
**IN RE: WATER CONTAMINATION LITIGATION      CIVIL ACTION NO. 16-C-6000**

**AUTHORIZATION**

TO WHOM IT MAY CONCERN:

NAME:

SS#:

DOB:

I, the undersigned, \_\_\_\_\_, do hereby authorize BrickStreet Mutual Insurance, Sedgwick CMS, HealthSmart Casualty Claims Solutions, Chartis Claims, Inc., and/or Insurance Commission to release (upon presentment of this Authorization or any photostatic copy of the same) to any member of the law firm of Jackson Kelly PLLC (Receiving Entity), or to any designee thereof, any information, medical records, or any other papers concerning any claim or claims filed by him against any employer or employers before the Workers' Compensation Old Fund, BrickStreet Mutual Insurance, Sedgwick CMS, HealthSmart Casualty Claims Solutions or Chartis Claims, Inc., as my employer's carrier. This Authorization also includes authority to copy any and all papers, records, etc. This Authorization is continuing in nature and is to be given full force and effect to discover information of any of the foregoing learned or determined after the date hereof. The Receiving Entity herein may distribute my records to any counsel in this litigation, upon payment to the Receiving Entity for the same, so long as my records are not disclosed outside of this litigation.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 2016.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA  
IN RE: WATER CONTAMINATION LITIGATION    CIVIL ACTION NO. 16-C-6000

**AUTHORIZATION FOR THE RELEASE AND  
DISCLOSURE OF EDUCATION RECORDS**

RE: \_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

I, the undersigned, \_\_\_\_\_, do hereby authorize  
\_\_\_\_\_ to release (upon presentment of this authorization or any  
photostatic copy of the same) to any member of the law firm of Jackson Kelly PLLC, or to any  
designee thereof, or to bearer, a complete copy of my records, including any evaluations, test  
results, scores, grades, behavioral reports and/or testing, or any other like papers. This  
authorization also includes authority to copy any and all papers, records, etc. This authorization  
is continuing in nature and is to be given full force and effect to discover information of any of  
the foregoing learned or determined after the date hereof.

DATED this \_\_\_\_ day of \_\_\_\_\_, 2016.

\_\_\_\_\_  
Plaintiff

\_\_\_\_\_  
Witness