

**AUTHORIZATION FORM  
FOR THE RELEASE OF ADVERSE EVENT REPORTS  
PURSUANT TO 21 C.F.R. § 20.63**

I, \_\_\_\_\_, hereby authorize and consent to the release of any and all Adverse Event reports relating to my medical condition(s) and care at issue, and with my name unredacted, including FDA Medical Device Reports and manufacturer-generated Issue Reports, to my counsel of record, as indicated below:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

\_\_\_\_\_  
Signature of Individual or Representative

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

\_\_\_\_\_  
Printed Name of Representative and Relationship to Individual (if applicable)

\_\_\_\_\_  
Description of Representative's Authority (if applicable)