

4.	I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the Claims Administrator to the Court presiding over the Program, Class Counsel, BP, any Appeals Judge and all other persons provided for under the terms of the Agreement to consider claims in the Program, and their respective attorneys, agents, employees, consultants, independent auditors, and experts (the "Receiving Parties"), and others deemed necessary by the Receiving Parties to assist in this litigation or claim.	
5.	I authorize the Claims Administrator to date this Authorization on my behalf when and if it determines that this Authorization is necessary for the processing of my Claim.	
Date Signed:	<p style="text-align: center;">____/____/____ (Month/Day/Year)</p>	<p style="text-align: center;">_____ Signature</p> <p style="text-align: center;">_____ Name (Printed or Typed)</p>
<p>If you are signing this Authorization as a representative on behalf of the employee identified at the top of this Form, describe your relationship to the employee and your authority to act on his/her behalf:</p>		
<p>You must attach proper documentation (e.g., power of attorney, letters of administration) authorizing you to act in this representative capacity.</p>		