HIPAA Patient Access & Directed Disclosure Request

By signing below, I hereby request that my physician, health care professional, hospital, pharmacy or other health care provider set forth below (collectively, my "**Specified Health Care Providers**") disclose and transmit my protected health information to Allergan and/or its designated service providers (collectively, "**Allergan**") in order for Allergan to: (i) provide me with communications about Allergan's reimbursement services; (ii) operate, administer, register me in and/or provide me with access to Allergan's online reimbursement services system; (iii) identify products and services that may be of interest to me and to provide me with communications about any such products and services; and (iv) develop, evaluate and improve products, services, materials and programs related to my condition or treatment. I request that any protected health information disclosed by my Specified Health Care Providers pursuant to this request is transmitted electronically in the following form and format:

- manually entered as a single patient into the Botox ONE™ system
- as part of a practice patient upload through the Botox ONE™ system

This request is made pursuant to 45 CFR § 164.524.

MY SPECIFIED HEALTH CARE PROVIDERS:

_____

_____

_____

_____ _____

Patient Signature Date

_____

Patient Name (please print)

_____

Patient's Date of Birth

_____

Patient's Address