

BOTOX[®] Reimbursement Solutions
PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION
FOR INSURANCE, REIMBURSEMENT, AND COVERAGE ASSISTANCE

State and federal laws protect the confidentiality of your medical information. When you sign this form, you are giving your physician permission to release confidential medical information to BOTOX[®] reimbursement solutions, including Allergan, to review and assess your insurance, reimbursement, and coverage for BOTOX[®] and BOTOX[®] related procedures. You are also giving BOTOX[®] reimbursement solutions, including Allergan and its employees, permission to release confidential medical information to insurance companies that we contact on your behalf, for this purpose. Such information may include your name, age, sex, medical diagnosis, insurance identifiers, employers, or medical providers you identify.

Please sign this form after reading the statement below:

I, _____, authorize my physician to release confidential medical information, on my behalf to BOTOX[®] reimbursement solutions, including Allergan and its employees in order to evaluate my insurance, reimbursement, and coverage for BOTOX[®]. BOTOX[®] reimbursement solutions also may contact my employer and/or medical provider(s), specifically _____, to complete my request. I verify that I have provided my medical information voluntarily and that BOTOX[®] reimbursement solutions will not release this oral or written information without my consent. In addition, I understand that BOTOX[®] reimbursement solutions cannot guarantee that the third parties contacted will keep my information confidential. I also understand that the third parties BOTOX[®] reimbursement solutions contacts may reside in states other than my own and may have a different set of confidentiality laws to follow. This authorization will remain in effect until I no longer need assistance from BOTOX[®] reimbursement solutions or until I revoke the authorization by calling or writing BOTOX[®] reimbursement solutions.

Signature

Date

Phone: _____
(area code)

Please fax the signed form to: 1-877-530-6680
or return the signed form to:
BOTOX[®] Reimbursement Solutions
PO Box 1379
San Bruno, CA 94066

If you have questions, please call: 1-800-44-BOTOX (option 4)