Authorization to Share Medical Information for the Reimbursement or Patient Assistance Programs

Provider's Instructions: Patients must complete this form before they are able to participate in the Program.

I, _____, authorize my physician(s), other healthcare providers and my health plan or insurers to provide Lash Group with medical information regarding the use or my need to use pharmaceutical products of McNeil Consumer & Specialty Pharmaceuticals. Lash Group administers the Reimbursement and Patient Assistance Programs (the "Programs") for McNeil Consumer & Specialty Pharmaceuticals.

This information may include data provided orally or in writing regarding my health and payment benefits that I could have. It may include copies of records of my healthcare providers or health plans regarding my health or health care.

Lash Group and McNeil Consumer & Specialty Pharmaceuticals will use and provide this information to determine if I am eligible for the Programs and to administer them. The people who work for and with Lash Group and McNeil Consumer & Specialty Pharmaceuticals may also see my information, but they may use it only to help me to obtain assistance with regards to the costs of my medications. I understand that they will do everything possible so as to maintain all information regarding myself confidential, but in the event it is accidentally disclosed, federal privacy laws will not protect it.

This Authorization will be valid until I stop participating in the Programs. In the event I change my mind before that time, I can notify, in writing, my healthcare providers and insurers that I do not wish for them to continue sharing my information with Lash Group or with McNeil Consumer & Specialty Pharmaceuticals. However, this will not modify the actions that they might have taken prior to my notification. I recognize that I have the right to see or copy the information that my healthcare providers or insurers have supplied to Lash Group and to McNeil Consumer & Specialty Pharmaceuticals.

I RECOGNIZE THAT I CAN REFUSE TO SIGN THIS FORM. My decision to sign or not sign this form will not change the treatment given by my healthcare providers or insurers. I recognize that if I refuse to sign this form I will not be able to continue receiving assistance from the Programs.

The patient signs here: _____ Date: _____

Patient's Name: _____

If the patient cannot sign, the patient's personal representative must sign below:

Patient's Name: _____

By: _____

(Signature of the person authorized to sign on behalf of the patient)

Describe your relationship to the patient and your authority to make medical decisions for the patient:

_____

The patient must receive a copy of this form.