

I authorize the use or disclosure of health information about me as described below.

1. I agree to permit my doctor and Teva Pharmaceuticals USA, Inc. and/or their agent to use and disclose health information about me.
2. I agree to permit Teva Pharmaceuticals USA, Inc. and/or their agent to receive the following health information about me: All health information related to reimbursement of certain costs related to lab work and physician counseling, and health information in my medical records that is relevant to my treatment with acitretin.
3. Teva Pharmaceuticals USA, Inc. and/or their agent is authorized to use the information to determine if I qualify for reimbursement under the T.A.P.P.: Take Action to Prevent Pregnancy program and, if it is determined that I qualify, in providing my doctor reimbursement for certain approved costs.
4. I understand that Teva Pharmaceuticals USA, Inc. and/or their agent is not a health care provider or health plan covered by federal privacy regulations, and when the information described above is disclosed to Teva Pharmaceuticals USA, Inc. and/or their agent it will no longer be protected by these regulations.
5. I understand that I may refuse to sign this authorization. If I do not sign, however, I understand that I will not be able to apply for or receive reimbursement of certain costs under the T.A.P.P. program.
6. I understand that I may revoke this authorization at any time by sending a written request to Teva Pharmaceuticals USA, Inc. and/or their agent, T.A.P.P., 3900 Paramount Parkway, Morrisville, NC, 27560-7200, except to the extent that action has been taken in reliance on this authorization.
7. This authorization expires 1 year after my participation in the T.A.P.P. program ends.

Signature of patient or representative

Date

Patient name

Name of personal representative (if applicable)
(A copy of this signed form will be provided to the patient)

Relationship to patient

PATIENT COPY

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TEVA PHARMACEUTICALS COPY