Johnson & Johnson
PHARMACEUTICAL RESEARCH
& DEVELOPMENT, L.L.C.

LoperamideHydrochloride
201107[redacted]

Authorization for Disclosure of Medical Information
(Please refer to the above AER # in all correspondence)

I hereby authorize my health care provider (named below) to disclose my health information, specifically medical records and follow-up information to the Global Medical Safety, J&J Pharmaceutical Research and Development, LLC for the purpose of adverse event reporting.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"; 45 CFR, Part 164) permits the disclosure of patient health information for public health activities such as adverse event reporting. I understand this information provided may be disclosed to others consistent with those obligations and no longer protected by these regulations.

I understand this authorization is voluntary and I have the right to access, rectify and revoke this authorization at any time, in writing. Your notice to revoke this authorization will not apply to actions taken prior to the date of your written request to revoke the authorization.

Name of the Patient (Please Print): _____

Signature of Patient, Patient's Guardian or Authorized Representative: _____

Date: _____ / _____ / _____

Name and address of the physician or other health care professional currently treating you:

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

If you wish to use any of the aforementioned, please send a formal written request with a photocopy of your ID to the following address:

Name: _____

Address: _____

Telephone Number: _____