INFORMATION AUTHORIZATION FORM

By signing below, I hereby authorize my CoolSculpting® physicians, health care professionals, or other health care providers (collectively, my "Health Care Providers") to disclose and transmit my protected health information to Allergan and/or its designated service providers (collectively, "Allergan") in order for Allergan to: (i) help enable my treatment and provide me with communications about my treatment (ii) operate, administer, register me in and/or provide me with access to Allergan programs and services; (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 authorize any protected health information disclosed by my Health Care Providers pursuant to this authorization to be transmitted electronically in whatever form and through whatever media, including the internet, as required by the purposes set forth. This authorization is made pursuant to
45 CFR § 164.524.

Print Name: _____ Signature:_____ Date: _____

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Please refer to the Allergan Privacy Statement at www.allergan.com/privacy and the California Privacy Policy at www.allergan.com/privacy/ccpa