AUTHORIZATION TO DISSEMINATE INFORMATION OF PATIENT MEDICAL RECORDS

I, _____, of legal age, of the following profession: _____, resident of _____, and of the following civil status:

☐ Single ☐ Married ☐ Window(er) ☐ Divorced ☐ Separated

hereby authorize Dr. José Raúl Montes and his associates, without any financial compensation, to show, illustrate, present, teach, instruct and educate in conferences, television, webpage and/or social medias (e.g., Facebook, Instagram, LinkedIn, Snapchat, Twitter, etc.), or any other place and date that may be necessary, but not limited to third parties, any photograph and/or descriptive documents that are held in my medical record and/or file, in the possession or under the custody of Dr. José Raúl Montes, as a result of any treatment, consultation and/or assessment that I have received under this physician.

I further authorize Dr. Montes (for medical and/or educational purposes, information and/or medical opinion about my condition), to instruct and explain my treatment, including the application and related information with the use of Botox® and/or any other product, treatment and/or medication.

This signor releases the doctor, his associates and/or institution from any liability for the disclosure and demonstration of any descriptive document (i.e., photos, graphics, drawings, reproduction of images, among others) referred to in this authorization.

☐ I authorize ☐ I do not authorize.

_____ _____

Patient's Signature Date

Rev. 1/19/17