
**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, 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 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