DR. VICTOR URZOLA
PLASTIC AND RECONSTRUCTIVE SURGERY
LASER CENTER

AUTHORIZATION TO USE / SHARE/ PUBLISH / DIFFUSE INFORMATION

THE PATIENT	
Citizenship	
ID Document	
ID Number	
Date of Birth	Día Mes Año
E-mail	
Telephone number	
Address	
Procedure	

Dr. Urzola wishes to inform THE PATIENT, explicitly, precisely and unambiguously, previous to the execution of the desired medical procedure detailed above, about the following:

A. DEFINITIONS: Dr. Urzola maintains a database with the personal information oh his patients, which includes all personal data, medical history, medical files, related documents, photographs/images and videos shot before, during and after the preferred surgical procedure, amongst others. Said information is subdivided, for comprehension purposes, into two groups, complying: (i) "ABSOLUTELY CONFIDENTIAL INFORMATION" and (ii) "CONSENTED INFORMATION".
   - The "ABSOLUTELY CONFIDENTIAL INFORMATION" corresponds to personal data which could facilitate direct or indirect identification/localization of the PATIENT, including, but not limited to: name, identification number, date of birth, e-mail address, phone number, address, photographs, images and/or videos of any kind which could reveal either directly or indirectly, his/her identity. This information is highly confidential, secret, not to be shared or discussed with third parties, wavered only due to legal exceptions when applicable. This information can be accessed without your authorization by DR URZOLA, my contributors, other doctors and professionals involved in your case that might need to contact you in order to coordinate, plan or execute any kind of treatment or paperwork as needed.
   - The "CONSENTED INFORMATION" is entirely anonymous (does not reveal your identity directly or indirectly). It involves a scientific and/or academic and/or promotional and/or commercial interest and DOES NOTINCLUDE the information complied within the "ABSOLUTELY CONFIDENTIAL INFORMATION". Said "CONSENTED INFORMATION" includes, but is not limited to: nationality, age (excluding your date of birth), race or ethnicity, profession, height, weight, body dimensions, eye color, facial shape or other parts of your body, clinical information, medical files, medical records and/or history, pre and post operational tests and evaluations, photographs and/or images and/or videos of any kind, which show your entire body or selected areas, shot before, during or after the medical procedure has taken place, along with any other information of scientific and/or academic and/or promotional and/or commercial interest, as long as none of the above reveal directly or directly your identity.

B. All information (ABSOLUTELY CONFIDENTIAL and CONSENTED INFORMATION) is kept as part of my protocol of medical records in order to guarantee an accurate history of my cases, comply with medical diligence when informing my specific professional criteria, and the "CONSENTED INFORMATION" is kept for scientific and/or academic and/or promotional and/or commercial

purposes. All this information is stored in a private archive with retrained entry, meeting with the security measures need to guarantee your safety.

C. Nevertheless and before the subscription of this document of authorization, you must be aware that the aforementioned **"CONSENTED INFORMATION"** (detailed above) will be **UTILIZED/ SHARED / PUBLISHED / DIFFUSED** by **Dr. URZOLA**, for scientific and/or academic and/or promotional and/or commercial purposes that may or may not generate a profit to **Dr. Urzola**. This **"CONSENTED INFORMATION"** would be viewed by other doctors and/or professionals, students, other patients, and specifically by the general public, information that could be utilized / shared / published / diffused through any media, including, but not limited to: printouts in general (scientific or not), internet, e-mails, television and all means of collective communication (private or collective in general), inside or outside of the country. Especially, **Dr. URZOLA** will be utilizing these information in a television show he intends to realize. Notwithstanding **Dr. URZOLA** guarantees that your identity will be thoroughly protected and that any utilization/ publication / diffusion of your **"CONSENTED INFORMATION"** will not allow your identification. This document intends for you to grant **Dr. URZOLA** fullauthorization to proceed according to what has been described in this paragraph.

D. Within the process of recollection of the data that conforms this information (**ABSOLUTELYCONFIDENTIAL INFORMATION** and **CONSENTED INFORMATION**) it is your obligation to answer all the questions that you are asked, doing this thoroughly, completely and providing the exact information you are required, in order to complete your medical history. You are required as well to allow our team members to take photographs and videos during pre-and post operators stages, as they are crucial information to achieve a successful surgical procedure and is needed in order to obtain comparative material. Not providing us with this information accordingly will force us to reject your case.

E. The signature in this document is absolutely **OPTIONAL** for the patient, which means you have the absolute right to **DECLINE** the execution of this document. Therefore, if you decide to reject the execution of this document all the information (**ABSOLUTELY CONFIDENTIAL INFORMATION** and **CONSENTED INFORMATION**) becomes confidential, private, restrained and of restricted use to **Dr. URZOLA** and his most essential collaborators only, who are obliged to keep all the information as privilege. Declining this document does not imply the rejection of the case by **Dr. URZOLA's** clinic.

F. In any case, **Dr. VICTOR JAVIER URZOLA HERRERA** is responsible of all your data/information and he commits to adopt all the technical and organizational measures necessary to guarantee the safety of all your information (**absolutely confidential information** and **consented information)**, to prevent its loss, non-authorized treatment or access, and any other action that is not accepted by this document.

G. You have the right to **REVOKE,** without retroactive effects, the authorization that by this mean you grant **Dr. URZOLA** to share the denominated **"CONSENTED INFORMATION"**, which you would have to perform in person at **Dr.URZOLA's** office, or by an email delivered from address you have recorded above**.** Please understand, is not impossible for us to accept revocations by other means although we have to confirm, up to where it's possible, the identity and authenticity of your communications.

H. As a patient you have the right to request a **"revelations report"** or **"diffusion inform"**, which is an written report reflecting to whom and/where your **CONSENTEDINFORMATION** has been utilized / shared / published / diffused. This requirement shall be done and presented in writing, personally to **Dr. URZOLA's** clinic. We cannot accept requests by email or any other similar mean.

I. THEREFORE, through the execution of this document **THE PATIENT** grants permission and absolute, express authorization to **Dr. VICTOR JAVIER URZOLA HERRERA,** so he can proceed to **UTILIZE/ SHARE / PUBLISH / DIFFUSE** patient's **"CONSENTED INFORMATION"** (detailed above), which could be used for scientific and/or academic and/or promotional and/or commercial purposes that may or may not generate a profit to Dr. Urzola. This **"CONSENTED INFORMATION"** will be viewed by other doctors and/or professionals, students, other patients, and specifically by the general public, information that could be used / shared / published / diffused through any media, including, but not limited to: printouts in general (scientific or not), internet, e-mails, television and all means of collective communication (private or collective in general), inside or outside of the country. Especially, **Dr. URZOLA** will be utilizing these information as part of a television show he

intends to produce. Notwithstanding **Dr. URZOLA** guarantees that your identity will be thoroughly protected and that any utilization/ publication / diffusion of your **"CONSENTED INFORMATION"** will not allow your identification.

J. Additionally, **THE PATIENT** understands and accepts that regardless the **"CONSENTED INFORMATION"** you have authorized **Dr. Urzola** to **USE/ SHARE / PUBLISH / DIFFUSE**, could generate profits to **Dr. URZOLA**, these profits are solely property of **Dr. URZOLA**. **THE PATIENT** therefore declines/surrenders any eventual claim of ownership and/or participation of these profits.

K. **THE PATIENT** declares: he/she had the opportunity to read this document in detail, to think it through, to understand it, to consult it with his/her counselors or people of his/her confidence, and he/she considers himself/herself dully informed to grant the authorization hereby contained and that all doubts referring to this document have been clarified in a satisfactory way.

L. **THE PATIENT** as well as **Dr. URZOLA** has read this document and they both have approved it. This document is executed in San Jose, Republic of Costa Rica, on the date stated above.

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THE PATIENT	DR. URZOLA
SIGNATURE	SIGNATURE
FULL NAME	FULL NAME: Víctor Javier Urzola Herrera
ID NUMBER	ID NUMBER: 109660360