Release of Medical Information

Permission to transfer records

I, _______________________________, with a date of birth,___________, give my permission for

Dr. Buss of Aesthetic Medicine of Southwest Montana to forward my hormone medical records to

Stephanie Morup, PA-C, (Certified Hormone Specialist) of Premier Aesthetic so that she can better understand my condition and continue care.

By putting my signature below, I understand that I give permission for records pertaining to hormone replacement therapy are to be sent that may contain information about: Doctors notes, lab results, prescription history.

Consent for release of medical records for ____________________________________

Patient's Signature_____________________________________ Date ____________

Upon receiving signed release records will be sent to:

Premier Aesthetics

1025 Shiloh Crossing Blvd. Suite 4

Billings, MT 59102

Phone: 406- 794-0003

Fax number: 406-206-4060