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

Dr. Lou Walters of Source Wellness Center so that he 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:

The Source Wellness Center

420 West Mendenhall Street

Bozeman, Montana 59715

Phone: 406-551-6175

Fax: 406-551-4444