CONSENT FOR BIOIDENTICAL HORMONE REPLACEMENT THERAPY PROGRAM

I, _____ request from (Glow Health Medical Clinic) to prescribe for me Bioidentical Hormone Replacement Therapy (BHRT).

I understand that compounded BHRT is not specifically approved by the FDA for preventive medicine and my request for BHRT is off-label.

I understand that the medical literature indicates that there may be health benefits to the use of BHRT and its long-term effects are undetermined. I understand that (Glow Health Medical Clinic) cannot guarantee any results or that there will be no harm. The potential health risks and benefits of using BHRT have been explained to me to my satisfaction.

I understand that any hormone replacement including BHRT has the potential to increase my risk of breast cancer and for this reason it is recommended that I have routine mammograms every 1-2 years after age 40 and prior to starting HRT. I understand that Estrogen alone can cause uterine cancer and that I will need to take this with Progesterone for uterine protection.

I understand that while Testosterone has been shown in medical literature to have benefits in women, that it is not currently FDA approved for the use in women and that if I choose to undergo this treatment, it is an off label treatment. I understand that this treatment requires routine lab monitoring.

I understand that BHRT is purely elective and that it may not be deemed medically necessary by insurance companies. I certify that I have read the above consent and fully understand it. I believe that I have adequate knowledge upon which to base this BHRT informed consent. I fully understand what I am signing and hereby request and consent to BHRT treatment.

Patient signature _____ Date _____

Patient Name: _____