INFORMED CONSENT FOR TESTOSTERONE REPLACEMENT THERAPY

I hereby request and authorize the administration of testosterone replacement therapy to me by **Superior T**. I understand that this therapy is provided to replace testosterone in males due to conditions associated with symptoms of deficiency or absence of endogenous testosterone. I also understand that use of this therapy to slow or reverse the natural aging process is not medically indicated. I further understand that the course of therapy may include the administration of Human Chorionic Gonadotropin (hCG) to prevent testicular atrophy and encourage my body's natural production of testosterone, and I consent to its administration. I further understand that this therapy is not provided or designed to enhance athletic ability or promote weight loss, and acknowledge and affirm that I am not requesting testosterone replacement therapy for such purposes. I affirm that I am not currently undergoing any other hormone replacement therapy or taking any testosterone supplementation, including anabolic steroids, testosterone gels, hormone boosters, pro-hormones, or any other substances designed or marketed as testosterone supplements. I understand and agree that taking any testosterone supplement or therapy not prescribed and administered by **Superior T** is medically contraindicated and will result in my being discharged as a patient by **Superior T**. I have discussed my complete medical history with my health care provider, including any history of breast or prostate carcinoma, heart disease, liver disease, or advanced renal disease. I have also provided **Superior T** with a list of all my current medications, including any oral anticoagulants. I acknowledge that accurate and complete medical information is critical to development of an appropriate therapy plan, and affirm that the information I provided was accurate and complete, to the best of my knowledge. I have been given the opportunity to ask questions and the health care provider has explained the benefits of the treatment, alternative forms of treatment, and risks involved. I have thoroughly discussed the risks and benefits of this therapy with my health care provider and I believe that I have sufficient information to give this informed consent.

_____ _____

Signature Date

_____ _____

Signature of Health Care Provider, credentials Date