## Informed Consent for IV Glutathione therapy

I, _____ hereby give consent to **(doctor's name)**, or one of the clinic assistants trained in IV therapy administration and under the guidance of a licensed and certified physician at **(clinic name)**, to perform intravenous therapy, specifically IV Glutathione for the purpose of treatment of _____.

I understand that IV Glutathione is a therapy widely used for the treatment of Parkinson's, chemotherapy toxicity, anemia of hemodialysis patients, kidney problems associated with heart bypass surgery, arteriosclerosis, diabetes, and male infertility. I understand that its usage may be considered controversial for the treatments listed above and for the generalized treatment of other neurological diseases. I have been advised that my treating physician believes that IV Glutathione has a positive clinical benefit for my condition. I have been informed that other treatment approaches have been used in my condition, including but not limited to, _____ _____, and no treatment, and these alternatives have been explained to me to my full satisfaction.

I understand the benefits of IV Glutathione may be limited if I am an active smoker, live a sedentary lifestyle, and have a diet that contains an excess of calories and/or a deficiency of nutrients. I understand that I may be asked to take oral supplements between treatments and a failure to take these supplements may reduce the benefits of the IV therapy and may even create unwanted effects of the IV therapy. I understand that a series of treatments may be anticipated. I understand that the IV glutathione may need to be repeated from time to time in the future in order to maintain the benefits. I understand that it is my option to stop treatments at any time without incurring further expense after I have decided that the treatments be discontinued.

I have been informed of possible risks and side effects including, but not limited to: discomfort at the injection site, thrombophlebitis, bruising, fainting, shock, infection, circulatory overload, fatigue, muscle cramps, allergic reaction, nerve/tendon/ligament damage, kidney problems, bone pain, arthritic pain, lowering of blood sugar (hypoglycemia), hemolysis, and flu-like symptoms. Most of the possible risks from IV glutathione therapy may be explained by the mobilization of mercury in a person with high levels of mercury in their body tissues. I understand that is important for **(doctor's name)** to determine whether my tissue mercury levels are high before performing Glutathione IV therapy. I may choose to forego testing for mercury levels and risk an adverse reaction from the Glutathione IV due to high tissue mercury levels. Even with this testing **(doctor's name)** and the practitioners at **(clinic name)** cannot guarantee there will not be an adverse reaction from the Glutathione IV even with normal or low tissue mercury levels.

If I have suffered from previous kidney disease or previous lab results showing decreased kidney function, I agree to execute a medical release so that all previously

## Informed Consent for IV Glutathione therapy

identified medical records of mine may be obtained from previous treating physicians, and I have disclosed openly any known previous kidney disorder. If **(doctor's name)** deems the information obtained to be insufficient to properly assess present kidney function I understand that I may be asked to have testing done to assist in the assessment of my present kidney function before IV therapy commences. I understand that this therapy may not be appropriate if I am pregnant. I understand the nature of the proposed procedure and the risks and dangers have been explained to me to my full satisfaction. I have not been asked to discontinue care with any specialists.

While I understand that there have been no warranties, assurances, or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through conversations with my treating physician, and through materials provided to me by the clinic to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy, and the procedures to be utilized, and all of my questions have been answered to my full satisfaction. I also acknowledge that I have received a copy of this signed informed consent form.

Date: _____ _____

Patient's signature

_____

Patient's name (printed)

Date: _____ _____

Physician's signature

_____

Physician's name (printed)