Holy Grail Health (hGH)

INFORMED CONSENT WAIVER

I, (please print patient name) PT:_____certify that the risks and benefits of intravenous DMSO (Dimethyl Sulfoxide) treatment have been explained to me.

DMSO has not been represented to me as a cancer cure, but only as a cancer treatment, which may help to promote healing and provide protection against side effects of radiation exposure from diagnostic imaging procedures I must undergo in order to assess my response to treatment.

It is also my understanding that clinical research evidence indicates that DMSO may help me to better recover from toxicity of prior chemotherapy, and that it improves circulation, thus reducing the risk of thrombosis (blood clot formation), one of the hazards of surgery.

I may have received various other treatments for my condition, some of which may have weakened my immune system, or I may be receiving DMSO late in the course of my illness. Under no circumstances will I hold Holy Grail Health.mx (hereinafter called "hGH") or its consulting physicians or clinics responsible for the outcome of my care, which may have involved multiple drugs and prior procedures which were beyond their control. It is my intent that this agreement shall be binding upon my heirs and survivors.

I understand that adjunct treatments may be offered in addition to DMSO, if necessary to achieve remission, always at my option. It has been explained to me that I may stop treatment at any time, by telling clinic staff that I do not wish to continue. However, since treatment formula and protocols are customized and all inclusive, fees are nonrefundable. I understand that Holy Grail Health (hGH) reserves the right to withhold formula for patient noncompliance or for any reason whatsoever.

I hereby grant release and permission for my medical records, including history and scan reports, to document the effectiveness of my treatment, for the benefit of the provider and fellow cancer patients. I also agree to maintain contact with HGH and provide follow -up scans and feedback on my welfare and state of health, once monthly for six months, then once every 6 months for 5 years, then once a year thereafter. I will do so either by phone or by email.

Diagnosis:_____

Date of Birth:_____**Pt. SSN**:_____**Pt. Email**:_____

Patient Cell Phone:_____

Does patient have IV access? (A port or a picc line?) Yes No

(If yes, please circle which) PICC / PORT

Estimated date of arrival:_____

Patient signature or next of kin:_____**Date**:_____

Witness signature:_____

Instructions: Print, complete, scan and email to info@holygrailcancercare.is

This will allow us to determine which clinic will be administering your treatment, based on type of malignancy and location. Please be sure to include your contact /cell phone number and an alternate number at which you can be reached.