

Informed Consent Waiver & Records Release

I, (please print) 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 provide protection against side effects of any radiation procedure I must undergo as treatment for my malignancy. It is also my understanding that clinical research evidence indicates that DMSO may help me to better tolerate chemotherapy, and that it also helps to promote better circulation and thus may help to reduce the risk of thrombosis (blood clot formation), one of the hazards of surgery. It has been explained to me that DMSO is legally administered "off label," meaning it is FDA approved for another medical purpose other than cancer treatment. 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 Camelot Cancer Care Inc. (hereinafter called "CCC") or its consulting physicians responsible for the outcome of my care, which may involve multiple medications and procedures, some of which were beyond their control. It is my intent that this agreement shall be binding upon my heirs and survivors. I understand that other alternative 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 CCC staff that I do not wish to continue. However, since treatment plans are customized and all inclusive, fees are nonrefundable. I understand that Camelot Cancer Care reserves the right to decline or terminate treatment for patient non-compliance or for any reason whatsoever. **I hereby grant release and permission for my medical records, including history & 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 CCC and provide followup scans and feedback on my welfare and state of health, once monthly for 6 months, then once every six months for five years, then once a year thereafter. I will do so either by phone, by mail, or by email.

Date: _____
Patient signature or next of kin

Date: _____
Witness signature

INSTRUCTIONS: Sign, date, and fax to Camelot Cancer Care Inc. at (918) 493-6589. This will allow us to order records and get your doctors appt. scheduled. Please be sure to include your contact/cell phone number _____ and the phone number of the clinic which will be transferring your medical records: _____

Diagnosis: _____ **Date of Birth:** _____ **To Medical Facility:**
Pt. ssn: _____ **Please mail patients' medical records to:**
Pt. Email: _____ **Camelot Cancer Care**
Does pt. have a port or picc line? **6804 S. Canton, Suite 110, Tulsa, OK 74136**
Yes__ No__ (If yes, circle which)
Estimated date of arrival _____ **Camelot Cancer Care Ph: 918.493.1011**