

Informed Consent Waiver & Records Release

Camelot Cancer Care Ph: 918.493.1011

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 promote healing and provide protection against side effects of radiation exposure from diagnostic imaging procedures I must undergo 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. 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 have involved multiple medications 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 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 noncompliance 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 follow-up 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 get your doctors appointment scheduled. Please be sure to include your contact/cell phone number _____ and an alternate number that you can be reached at: _____

Diagnosis: _____ Date of Birth: _____

Pt. SSN: _____ Pt. Email: _____

Please fax patients' medical records to Camelot Cancer Care at: 918-493-6589

If you are unable to fax, please mail records to: Camelot Cancer Care Inc. Attn: Records Dept. 6804 S. Canton Suite 110 Tulsa, OK 74136

Does patient have a port or picc line? Yes _____ No _____ (If yes, circle which) PICC PORT
Estimated date of arrival _____