Peptide Therapy Consent Form

Peptides are small chains of amino acids that can have biological activity. They are mostly naturally occurring. Some peptides are FDA approved for the treatment of certain diseases. Other peptides used clinically are prepared by duly registered compounding pharmacies complying with all state and federal laws. Peptides can be administered in various presentations, including but not limited to oral, intravenous, subcutaneous, intramuscular and intranasal routes. Understanding this, I hereby acknowledge and consent to the following:

- My physician, Dr. _____, has discussed with me the possibility of integrating peptide therapy into my current treatment regime.
- I understand that the use of this peptides is not necessarily approved for my medical conditions and that my physician is providing this, following the principles of the practice of medicine and the laws regulating compounding pharmacies, as a complement to my current treatments.
- As with any other drug, peptide therapies can have side effects, including but not limited to:
    - Nausea
    - Vomiting
    - Fever
    - Injection site reactions (pain, rash, bleeding)
    - Allergies, including life threatening allergies
    - Additional side effects not listed may also occur
- I understand that alternatives to peptide therapy are:
    - Do nothing
    - Standard medication use
    - Surgery or other therapeutic intervention
- I furthermore understand that Peptide therapy is being used as part of an integrative treatment approach.

Having read this, I hereby acknowledge that I am voluntarily undergoing peptide therapy and that I hereby relieve Dr. _____ of any legal responsibility regarding side effects or complications that may occur due to receiving peptide therapies). I certify that if any concerns or side effects occur, I will promptly notify Dr. _____ . I also understand that Dr. _____ is not responsible for any manufacturing issues related to these peptides, such as sterility and potency, which are the sole responsibility of the compounding pharmacy preparing them.

I certify that I understand all the above information and that I have no questions about this.

Patient name:	Physician name:
Date:	Date:
Signature:	Signature: