**INFORMED CONSENT**for Ozone/UV IV Therapy

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction:**

This document provides information about Ozone/UV IV Therapy which consists of Major Autohemotherapy (MAH) and Ultraviolet Blood Irradiation (UBI) with intravenous (IV) administration. It is important that you read and understand this information before giving your consent to undergo the treatment. Please ask any questions you may have to ensure you are fully informed.

**Purpose of O3UV:**

O3UV is a procedure that involves the withdrawal of a small amount of your blood, mixing it with medical-grade ozone, and then re-infusing the treated blood back into your body by way of UV light. This therapy is intended to enhance oxygen utilization, improve circulation, and support the immune system. It may be used for various medical conditions, including chronic infections, autoimmune disorders, and as a complementary therapy for general wellness.

**Procedure Description:**

1. A healthcare professional will draw approximately 60-1200cc of your blood using a
sterile syringe.
2. The drawn blood will be mixed with a specific concentration of ozone, a form of oxygen.
3. The ozone-treated blood will then be re-infused into your body through an IV line also bypassing the UV light.
4. The entire procedure typically takes about 30-60 minutes.

**Potential Benefits:**

* Enhanced immune system function.
* Improved oxygenation and circulation.
* Potential reduction in symptoms related to chronic infections or inflammation.
* Support for detoxification processes.
* General improvement in energy levels and overall wellness.

**Potential Risks and Side Effects:**

While O3UV IV is generally considered safe, it is important to understand the potential risks and side effects, which may include:

* **Injection site reactions:** Pain, bruising, or infection at the needle insertion site.
* **Allergic reactions:** Though rare, there is a potential for an allergic response to ozone or other components used in the procedure.
* **Dizziness or lightheadedness:** This may occur during or after the procedure due to changes in blood pressure or oxygen levels, vasovagal response or changes in blood sugar.
* **Hemolysis:** The destruction of red blood cells can occur if the ozone concentration is too high.
* **Herxheimer Reaction:** A temporary worsening of symptoms due to the release of toxins as pathogens are killed.
* **Fatigue or malaise:** Some patients may experience tiredness after the procedure.
* **Rare and serious complications:** These are unknown when the therapy is done in the proposed, safe manner.

**Alternatives:**

You have the right to consider alternative treatments or to decline this treatment altogether. Other potential therapies may include conventional medications, other forms of ozone therapy, or lifestyle modifications. Please discuss these options with your healthcare provider.

**Contraindications:**

O3UV may not be appropriate for all patients. You should inform your healthcare provider if you have any of the following conditions:

* Currently taking antibiotics
* Currently taking medications causing light sensitivity
* G6PD Deficiency
* Allergy to heparin or anticoagulants
* Severe cardiovascular disease
* Hyperthyroidism
* Bleeding disorders
* Recent heart attack or stroke
* Severe anemia
* Acute alcohol intoxication
* Pregnancy or breastfeeding

**Patient Responsibilities:**

* Inform your healthcare provider of all medications, supplements, and treatments you are currently using.
* Follow all pre-treatment and post-treatment instructions provided by your healthcare provider.
* Report any adverse reactions or concerns immediately.

**Confidentiality:**

Your medical records and the details of your treatment will be kept confidential in accordance with applicable laws and regulations. Only authorized personnel will have access to your information unless you provide written consent for disclosure.

**Consent Statement:**

By signing this form, I acknowledge that:

1. I have read and understood the information provided above.
2. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.
3. I understand the potential benefits, risks, and alternatives associated with Major Autohemotherapy.
4. I voluntarily consent to undergo Major Autohemotherapy IV treatment.
5. I understand that I may withdraw my consent at any time without penalty.



**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_