

## Informed consent and petition for assistance

I,.....Age.....

with ID card number: .....(copy attached)

living in .....

In full possession of my mental powers and fully aware of my decisions, I give my consent, on my own initiative and with knowledge of the facts, to the use of chlorine dioxide in the form of CDS in accordance with current legislation and in accordance with the WMA (World Medical Association) Protocols 2013 of Helsinki for

Dr. ....in .....

Below I make the following statement:

1. I am considered a palliative patient with no conventional medical solution for my illness. I independently searched for an alternative self-help treatment that is not yet officially approved as medicine by the institutions in my country of residence.
2. I ask the above-mentioned healthcare professional to accompany me as a personal advisor in my self-treatment for safety reasons and for correct dosage advice.
3. Therapeutic effect: I am aware that chlorine dioxide in the form of CDS (chlorine dioxide in aqueous solution) is used therapeutically to treat my diagnosis .....
4. I have been properly informed by the above-mentioned doctor about the possible benefits and risks associated with taking CDS, including information about possible side effects such as nausea, diarrhea, pain or headache, and others.
5. I understand that using CDS is a personal choice and that my consent is voluntary. I had the opportunity to ask questions and clarify any doubts before making this decision, while also informing myself about the human science studies on the subject.
6. I understand that there are other treatment alternatives, and I have had the opportunity to discuss and consider these options with my doctor. I chose CDS as part of my treatment plan based on my own research and evaluation of the information provided.
7. I agree to report to my doctor any symptoms or adverse reactions that occur while taking CDS. I understand that it is important to communicate any changes in my health in a timely manner so that my doctor can evaluate and adjust my treatment accordingly.
8. I understand that this consent can be withdrawn at any time and that I have the right to obtain a second medical opinion before starting treatment with chlorine dioxide in CDS form. I acknowledge that it is my responsibility to inform my doctor if I decide to stop or change my treatment.
9. I agree to follow all instructions and recommendations from my doctor regarding the use of chlorine dioxide in CDS form. This includes the appropriate dosage, frequency of administration and any other advice relating to the safe and effective use of this remedy.
10. The results can be used for research and potential medical publications.

In accordance with universal ethical principles, the doctor accepts due to :

1. Well-being is our primary concern and thus fulfills his Hippocratic Oath.
2. The data and results obtained are used for educational purposes.
3. If the patient's request is denied, it could indicate that the doctor is not fulfilling their legal obligation to provide assistance.

I have read and understood the information provided. All my questions were answered. I hereby voluntarily give my consent to participate in this study/treatment and hereby waive any civil, criminal or administrative claims against the above-mentioned doctor in connection with the present treatment.

Patient's signature: \_\_\_\_\_ Date and place: \_\_\_\_\_

Signature of the witnesses:

Witness 1: \_\_\_\_\_ ID card number:: \_\_\_\_\_

Signature of the witness: \_\_\_\_\_

Witness 2: \_\_\_\_\_ Identity card number: \_\_\_\_\_

Signature of the witness: \_\_\_\_\_

The Doctor/ Therapist \_\_\_\_\_