

**Informed Consent and Authorization  
For Treatment Statement**

1. I understand that blood testing is strongly recommended prior to undergoing a long-term course of HGH therapy. Although I may decline this recommendation, I understand that in the event of rare significant side effects of this therapy, it may be more difficult to give optimal treatment in the absence of this laboratory testing information.
2. I understand that it is my obligation to be as open and candid on my medical questionnaire as possible, as the reviewing doctor can only optimize my therapy to the extent that my health status is completely understood.
3. I understand that the reviewing doctor for my HGH program is not my primary physician and is not principally responsible for my medical care. I understand that it is completely my responsibility to undergo physical examination and medical evaluation as dictated by my primary care physician. I understand that my primary care physician should be made aware of my HGH therapy, as well as any other significant therapies I may be taking.
4. I understand that telephone consultations may be arranged with my reviewing doctor regarding any questions about my HGH therapy and my clinical response. I further understand that any such consultations will be deemed to have occurred in the state where the reviewing physician is physically located and licensed to practice medicine.
5. I understand that my reviewing physician cannot guarantee any results from my course of HGH therapy. I further understand that no guarantee can be given to assure that new medical conditions might not develop or that preexisting medical conditions might not worsen or become more clinically apparent.

By my signature below, I assert that I have read and understood the above consent provisions.

Signature\_\_\_\_\_ Date\_\_\_\_\_

Print Name\_\_\_\_\_

Witness\_\_\_\_\_ Date\_\_\_\_\_

Print Witness Name\_\_\_\_\_