INFORMED CONSENT FOR TREATMENT WITH CJC 1295 and Ipamorelin

I seek the medical services of insert _____ of _____ and their employees (collectively _____). I am executing this consent to confirm my discussion with insert Physician name and my understanding of the risks, benefits, and alternatives to treatment with CJC 1295 and Ipamorelin. The goal and possible benefits of this therapy are to try and prevent, reduce or control the dysfunction associated with the aging process, through hormonal balancing, control of oxidative stress, and other clinically significant therapeutic agents. However, I understand that this treatment may be viewed by the mainstream medical community as new, controversial, and unnecessary by the Food and Drug Administration ("FDA").

Benefits and General Information
CJC 1295 is an analog of the growth hormone releasing hormone (GHRH) which increases endogenous growth hormone release. Ipamorelin is a selective ghrelin secretagogue which also encourages endogenous growth hormone release. Together, these two peptides are synergistic to increase serum growth hormone levels and thereby increase serum levels of IGF1 and IGFBP3.

2 . Risks
The following are examples of some of the possible specific risks/adverse reactions reported for therapy that may be prescribed for me. Some of these risks/adverse reactions are for prescription drugs derived from the official FDA labeling requirements for these drugs. At physiological blood levels, there are not expected to be any significant risks/adverse reactions as long as full medical disclosure is achieved from the patient during the total time of therapy.

By signing this form, I understand the possible risks associated with this treatment. For CJC 1295 and Ipamorelin adverse reactions include injection site redness, transient high blood sugar, development of antibodies to CJC 1295, and water retention. These side effects are dose related and usually eliminated by adjusting the dosage. This drug should not be used in patients with known cancer.

I understand that _____ will monitor my treatment in an effort to prevent any side effects, but cannot guarantee that I will not experience any side effects or adverse reactions. I understand that, as with any health treatment, there is no guarantee I will obtain satisfactory results through the use of this therapy. I understand the use of this treatment does not preclude me from using other treatments as well, though I recognize that I should inform any practitioners I am seeing about the various treatments I am using.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

I certify that I have read the foregoing Informed Consent, discussed the issues noted above, had opportunities to ask questions, and agree and accept all of the terms above.

PATIENT NAME: _____

PATIENT SIGNATURE X_____ DATE:_____

If someone other than the patient is signing this form, indicate the name of the person, title, and

authority to sign this form below.

_____
Name

_____
Title/Relationship to Patient

Please provide authority to sign document: _____

I have explained this Informed Consent and answered all questions, and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed and has consented.

Physician Name: _____

Physician Signature: _____ Date: _____