Immunotherapy Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Purpose of Treatment

The purpose of the immunotherapy is to enhance your body's immune response against [specific condition].

Procedure Description

You will receive [details about the treatment procedure, including frequency, administration method, etc.].

Risks and Benefits

While several benefits may arise from this treatment, including [list potential benefits], there are also risks involved which may include [list potential risks].

Confidentiality

Your treatment and personal information will be kept confidential according to HIPAA regulations.

Consent Statement

I, the undersigned, have read and understood the information provided in this consent form. I have had the opportunity to ask questions and have received satisfactory answers.

Patient Signature: _____

Date: _____

Provider Name: _____

Provider Signature: _____

Date: _____