 21097 NE 27th Court, Suite 200B

 Aventura, FL 33180

 305-405-1595

Patient Informed Consent

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned hereby authorize an infusion treatment to be performed by the staff at Infusion and Immunotherapy Center of South Florida. This infusion treatment has been ordered by my referring physician.

• I have been explained the purpose of the treatment.

• All of my questions have been answered to my satisfaction regarding this type of infusion treatment.

• I have been explained the potential risks and benefits associated with this type of infusion treatment.

• I am aware that there may be side effects associated with receiving this infusion treatment and agree to have the infusion performed and receive emergency treatment for any side effects if needed during my infusion.

Signature of Patient/Guardian Printed Name Date/Time