**Thisgift.org – Client Consent & Release Form**

*For Ibogaine Treatment in Mexico*

**Client Information**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Consent**

This form confirms your understanding and agreement regarding:

* Financial assistance provided by **Thisgift.org** is for the purpose of supporting access to medically supervised Ibogaine treatment in Mexico.
* Thisgift.org is **not a medical provider** and does not administer Ibogaine treatment.
* All medical decisions, procedures, and treatment are the responsibility of the licensed facility and its staff.

**Acknowledgement of Risks**

I understand that:

* Ibogaine treatment carries potential risks, including but not limited to: heart complications, seizures, nausea, psychological distress, and in rare cases, death.
* A full medical screening is required before treatment, and I must disclose all relevant medical history and current medications to the treatment provider.
* Thisgift.org is not responsible for medical outcomes, complications, or side effects of treatment.

**Confidentiality**

* Information provided in my application and during this process will be kept private and confidential by Thisgift.org.
* Information may only be shared with the treatment facility and staff as necessary for treatment planning and safety.

**Release of Liability**

By signing this form, I agree to release, indemnify, and hold harmless **Thisgift.org, its staff, volunteers, and affiliates** from any liability related to:

* Medical procedures, risks, or side effects of Ibogaine treatment.
* Travel, lodging, or personal expenses associated with receiving treatment.
* Any outcomes, whether positive or negative, resulting from Ibogaine treatment.

**Client Declaration**

I certify that:

* I have provided accurate and complete information regarding my medical history and personal circumstances.
* I have read and understood this consent form, and all my questions have been answered to my satisfaction.
* I voluntarily choose to proceed with Ibogaine treatment in Mexico with the understanding of the risks and limitations described above.

**Signature**

**Client Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**Witness Name (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_