PUBLIC HEALTH DIVISION
CENTER FOR HEALTH PROTECTION
Oregon Psilocybin Services
http://oregon.gov/psilocybin

Informed Consent

Introduction:

In the State of Oregon, psilocybin services include a preparation session, administration session, and integration session. You should receive this informed consent form prior to or during your preparation session. During the preparation session, your facilitator will review and discuss this form with you. Please make sure you read and understand every section because you must sign the form before the administration session begins. If you do not understand any part of this document, please ask your facilitator for clarification before signing.

I have been informed of and understand the following:
(Please initial each item below)

1. ____ I have reviewed the Psilocybin Services Client Bill of Rights, my facilitator has explained it to me, and I understand my rights as a client.

2. ____ I understand that psilocybin services do not require medical diagnosis or referral and that psilocybin services are not a medical or clinical treatment.

3. ____ I understand that psilocybin has not been approved by the Food and Drug Administration and the federal government currently classifies psilocybin as a Schedule I controlled substance under the Controlled Substances Act.
    a. Federal law prohibits the manufacture, distribution, and possession of psilocybin even in cities and states that have adopted laws to allow its possession or use.
    b. Despite its federal Schedule I status, research suggests that psilocybin is very unlikely to be addictive. Additionally, research and other information suggests that psilocybin may improve symptoms of depression, anxiety, end of life distress, various forms of trauma, and problematic substance use.

4. ____ I understand that the risks, benefits, and drug interactions of psilocybin are not fully understood, and individual results may vary.

5. ____ I understand that some people have found psilocybin administration sessions to be challenging or uncomfortable. Common potential side effects include nausea, mild headache, fatigue, anxiety, confusion, increased blood pressure, elevated heart rate, paranoia, perceptual changes, altered thought patterns, reduced inhibitions, recovery of repressed memories and past traumas, and altered perception of time and one's surroundings. If they occur, these side effects are usually mild and temporary. Because the potential risks and benefits of psilocybin administration are not fully understood, there may be unanticipated side effects.

6. ____ I understand that if I am taking prescription medications or have a medical condition or mental health condition, I should consider consulting with a medical or clinical provider before participating in an administration session.

7. ____ I understand that psilocybin is derived from fungi. If I have a known mushroom allergy, I should consult with a medical or clinical provider before participating in an administration session.

8. ____ I understand that the risks of consuming psilocybin while pregnant or feeding with breast milk are unknown.

9. ____ I understand that facilitators may not use touch while providing psilocybin services without my prior written consent. My facilitator and I have discussed acceptable types of supportive touch and the requirement to provide prior written consent prior to the start of my administration session.

10. ____ I understand that facilitators may be mandatory reporters of abuse. If my facilitator is a mandatory reporter, they have shared this information with me and explained their legal obligations to report abuse.

11. ___I understand that facilitators have a duty to report misconduct that harms or endangers a client to the Oregon Health Authority. If the misconduct presents an immediate risk to health and safety, facilitators have a duty to contact emergency services.

12. ____ I agree to follow my agreed upon transportation plan. I understand that a facilitator may contact emergency services if failure to follow my transportation plan presents a risk to my safety or the safety of others.

13. ____ I understand that consuming psilocybin is completely voluntary and I may decide not to consume psilocybin at any time.

14. ___ I understand that I have the right to update my client information form prior to beginning an administration session and I have the right to receive a copy of my client information form upon request.

15. ____ I understand that if de-identified data collected by facilitators and service centers is shared with people and institutions outside of the facilitator or psilocybin service center, I must be provided with a disclosure form that describes who will receive the data and how it will be used, and that I have the opportunity to opt-out of having my de-identified data provided to third parties.

16. ____I understand data that may be used to identify me as a client will only be shared to the extent permitted or required by law. Specifically, ORS 475A.450 allows disclosure in the following circumstances:
    (1) When the client or a person authorized to act on behalf of the client gives consent to the disclosure;
    (2) When the client initiates legal action or makes a complaint against the psilocybin service center operator, the psilocybin service facilitator, or the employee;
    (3) When the communication reveals the intent to commit a crime harmful to the client or others;
    (4) When the communication reveals that a minor may have been a victim of a crime or physical, sexual or emotional abuse or neglect; or
    (5) When responding to an inquiry by the Oregon Health Authority made during the course of an investigation into the conduct of the psilocybin service center operator, the psilocybin service facilitator, or the employee under ORS 475A.210 to 475A.722.

17. ____I understand that my facilitator may take short restroom breaks during my administration session.

18. ____ I understand that for my own safety, leaving a psilocybin service center during an administration session once it has begun is strongly discouraged. Doing so could lead to safety and legal risks.

19. ____ I understand and have been informed of the potential benefits, risks, and complications of psilocybin services with my facilitator to the extent that they are known.

20. ____ My facilitator has shared locations of client restrooms and protocols for use of restrooms during an administration session.

21. ____My facilitator has shared information regarding verification of license status and process for making complaints to the Oregon Health Authority.

22. ____ I have had the opportunity to ask questions regarding anything I may not understand or that I believe should be made clear.

23. ____ If participating in a group administration session, I understand that I will be experiencing the effects of psilocybin in the presence of other clients who are also experiencing the effects of psilocybin and may be reacting to the experience in a different manner.

24. ____ I understand that activation times for psilocybin products are variable and cannot be accurately predicted.

25. ____I acknowledge that the risks and benefits of consuming doses greater than 35 mg of psilocybin analyte are unknown.

26. ____If consuming whole fungi during an administration session, I understand that psilocybin content can vary between individual fruiting bodies.

27. ___I understand that the risks and benefits of repeated psilocybin use are unknown.

28. ____I understand that a facilitator has a duty to call emergency services if required and a client assumes responsibility for costs of emergency services.

29. ____I understand that I will be required to identify an emergency contact and a facilitator or service center may contact this person in the event of a medical or other emergency.

30. ____ I understand that I may be charged a cancellation fee if I cancel a scheduled preparation, administration, or integration session.

31. ____ I understand that I have the right to choose my facilitator and if a facilitator has supervisory, evaluative, or other authority over me, I will be provided an opportunity to receive psilocybin services from another facilitator.

32. ____ I understand that service center licensee representatives may be present during my administration session to assist licensed facilitators with operations.

_____
Name (Print)

_____ _____
Signature Date