Patient Name________________________________
Date of Birth ______________________________

CONSENT TO DISCARD FROZEN EMBRYOS

I/We request that some or all of our cryopreserved (frozen) embryos no longer be stored at Ohio Reproductive Medicine. I/We request that the embryos be thawed in the laboratory in a manner that will render them non-viable.

If you are currently expecting, Ohio Reproductive Medicine recommends that you **not** discard your frozen embryos until after the birth of your baby. If you have any questions, please contact your physician.

Our instructions are as follows:

I. Choose one of the two options below regarding the number of embryos to be discarded:

a. I/We desire that **ALL** of my/our embryos stored at Ohio Reproductive Medicine be discarded.

______________ ______________
Patient's Initials Partner's Initials (if applicable)

b. I/We desire that **ONLY** embryos frozen on **the following dates** be discarded:

List dates of freeze (month/day/year) _________________________________

______________ ______________
Patient's Initials Partner's Initials (if applicable)

II. Choose one of the three options below regarding the handling of the embryos after they are thawed

a. I/We desire that Ohio Reproductive Medicine discards the embryos according to their protocol.

______________ ______________
Patient's Initials Partner's Initials (if applicable)

b. I/We donate my/our embryos for laboratory training and/or for research purposes aimed at improving IVF treatment outcome. If discarded embryos are studied as part of a research project it would only be done in compliance with Institutional Review Board (IRB) policy. All materials used for research purposes would be de-identified. No materials would be used to establish a pregnancy.

______________ ______________
Patient's Initials Partner's Initials (if applicable)

c. I/We wish to take the embryos with us for disposal as we see fit.

______________ ______________
Patient's Initials Partner's Initials (if applicable)

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By signing this document, I/we acknowledge that our Ohio Reproductive Medicine physician and caregivers have obtained from me/us informed consent to proceed with discarding of embryos. I/We release the physicians, nurses, technicians, and other Ohio Reproductive Medicine staff from any responsibilities regarding these embryos after they are discarded.

It is required that you have this document witnessed at Ohio Reproductive Medicine, if unable because of distance the default is to have this document officially notarized.

Witness of Consent Form (if this form is completed no need to complete notarization form)

______________________________ ______________________________ ________/________/________

Patient Name (print) **Patient Signature** **Today's Date** (MM/DD/YYYY)

________/_________/________

Date of Birth (MM/DD/YYYY)

PATIENT- TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: _____

ID NUMBER:________________State/Country:_________________Expiration Date: ________/_______/________

Date (MM/DD/YYYY)

______________________________ ______________________________ ________/_______/________

Witness Name and Title (print) **Witness Signature** **Today's Date** (MM/DD/YYYY)

______________________________ ______________________________ ________/_______/________

Partner Name (if applicable, print) **Partner Signature** **Today's Date** (MM/DD/YYYY)

________/_________/________

Date of Birth (MM/DD/YYYY)

PARTNER - TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: _____

ID NUMBER:________________State/Country:_____________ Expiration Date: ________/_______/________

Date (MM/DD/YYYY)

______________________________ ______________________________ ________/_______/________

Witness Name and Title (print) **Witness Signature** **Today's Date** (MM/DD/YYYY)

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Notarization Form **(This form is only needed if not able to have witnessed at Ohio Reproductive Medicine)**

________________________ ________________________ ______/______/______

Patient Name (print) **Patient Signature** **Date of Birth** (MM/DD/YYYY)

State of:________ County of: _____________

On this _______ day of _______________________ 20_____, before me, the undersigned notary public, personally appeared ______

____, proved to me through satisfactory evidence of identification, which were______

______________________, to be the person whose name is signed on the proceeding or attached document in my presence.

ID NUMBER:_________________________ Expiration Date: ______/______/______ (MM/DD/YYYY)

______/______/______
Today's Date (MM/DD/YYYY)

____
Notary Signature

____
Title
My appointment expires: /______/______ (MM/DD/YYYY)

________________________ ________________________ ______/______/______

Partner Name (if applicable, print) **Partner Signature** **Date of Birth** (MM/DD/YYYY)

State of:________ County of: _____________

On this _______ day of _______________________ 20_____, before me, the undersigned notary public, personally appeared ______

____, proved to me through satisfactory evidence of identification, which were______

______________________, to be the person whose name is signed on the proceeding or attached document in my presence.

ID NUMBER:_________________________ Expiration Date: ______/______/______ (MM/DD/YYYY)

______/______/______
Today's Date (MM/DD/YYYY)

____
Notary Signature

____
Title
My appointment expires: /______/______ (MM/DD/YYYY)

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