EMORY
REPRODUCTIVE CENTER
550 Peachtree St. Suite 1800, Atlanta GA 30308
(404) 778-3401 FAX (404) 686 4501 CLIA ID 11D0897047

**Place Patient Sticker Here*

Name: _____
MRN: _____
DOB: _____

CONSENT FOR DISPOSITION OF FROZEN EMBRYOS

We, _____ , _____, and _____ , _____,
Patient Name | Date of Birth | Partner's Name | Date of Birth
have embryos resulting from in vitro fertilization procedures that are in frozen storage at the Emory Reproductive Center of the Emory Clinic, Inc. (Referred to herein as "Emory"). We, Patient and Partner, no longer desire to maintain storage of the frozen embryos and hereby instruct Emory to dispose of all such material in the manner described below. (Select one option. Both Patient and Partner must initial the same option).

____ ____ Thaw and destroy all frozen embryos belonging to us and presently in storage at Emory.

____ ____ Donate the frozen embryos to Emory Research (please also sign Emory Research consent).

____ ____ Donate to a named individual. Please note that this option requires a legal clearance letter or a separate legal agreement and completion of pre-screening and testing, as may be required by the FDA or other agencies.

Name of the Individual:_____by date of: _____
Laboratory to which embryos will be sent: _____ Laboratory Phone Number:_____
Laboratory Address:_____

It is understood that if we select this option, we waive any right and relinquish any claim to the donated embryos or any resulting pregnancy or offspring as outlined in a separate legal agreement. We understand that the named individual receiving the donated embryos may regard the donated embryos and any offspring resulting therefrom as her/their own children. We understand and agree that we are responsible for making all arrangements for the transfer of embryos to the named individual and all expenses associated with the transfer.

We, Patient and Partner, attest that these instructions concerning disposition of our frozen embryos represent our present desires and that any prior instructions given to Emory concerning storage and disposition of these materials are null and void.

CONSENT
We, Patient and Partner, understand that the instructions given in this document are irrevocable. We understand and agree that upon receipt of this document, Emory will act upon the instructions given herein and the results of these actions are not reversible. We understand and accept the conditions, risks and limitations associated with these instructions. We therefore voluntarily consent to Emory acting upon our instructions as designated above by our initials. We are 18 years of age or older.

RELEASE
We agree to absolve, release, indemnify, protect and hold harmless the Emory Clinic, Inc., its officers, directors, agents and employees from any and all liability for any adverse outcome, or consequence, however remote, arising from disposal of our frozen embryos as instructed herein. In addition, we release, discharge and acquit The Emory Clinic, Inc., its officers, directors, agents and employees from any and all liability in connection with subsequent disputes arising between Patient and Partner or any other third party in connection with the control and/or disposition of our frozen embryos.

_____
PATIENT SIGNATURE DATE TIME

PATIENT IDENTIFICATION: (filled out by staff member)
Type Viewed:_____ Exp. Date:_____Confirmed on Date:_____

Emory Reproductive Center
Attn: Clinic Operations Manager
550 Peachtree St., Suite 1800
Atlanta, GA 30308

PARTNER SIGNATURE DATE TIME

PARTNER IDENTIFICATION: (filled out by staff member)
Type Viewed: _____ Exp. Date: _____ Confirmed on Date: _____

STAFF MEMBER - NAME & TITLE STAFF MEMBER – SIGNATURE DATE TIME

OR

NOTARY – PRINT NAME NOTARY – SIGNATURE DATE TIME

SEAL

Instructions to Patient

In order for this consent for the disposal of frozen embryos to be acceptable, we must receive a copy of the notarized form from the Patient and Partner. This form can be sent via patient portal. Alternatively, the Patient and Partner may sign this form in the presence of an Emory Reproductive Center clinical staff member with a state-issued ID.

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Atlanta, GA 30308