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 DISPOSAL OF FROZEN OOCYTES

I,_____ ,_____, (woman, referred to herein as "Patient")
Printed Name Date of Birth
have oocytes frozen in storage at the Emory Reproductive Center of the Emory Clinic, Inc. (referred to herein as "Emory"). I, Patient, no longer desire to maintain storage of the frozen oocytes and hereby instruct Emory to dispose of all such material in the manner described below. (Select one option. Patient must initial the same option).

_____Thaw and destroy all frozen oocytes belonging to me and presently in storage at Emory.

_____Donate the frozen oocytes 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 oocytes will be sent: _____ Laboratory Phone Number:_____
Laboratory Address:_____

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

I, Patient, attest that these instructions concerning the disposition of my frozen oocytes represent my present desires and that any prior instructions given to Emory concerning storage and disposition of these materials are null and void.

CONSENT
I understand that the instructions given in this document are irrevocable. I 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. I understand and accept the conditions, risks and limitations associated with these instructions. I therefore voluntarily consent to Emory acting upon my instructions as designated above by my initials. I am 18 years of age or older.

RELEASE
I 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 my frozen oocytes as instructed herein. In addition, I 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 any other third party in connection with the control and/or disposition of my frozen oocytes.

_____
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

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

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