BOSTON IVF

Patient Name_____

Date of Birth _____

CONSENT TO DISCARD
FROZEN EGGS

I/We request that some or all of my/our frozen eggs no longer be stored at Boston IVF**.** I/We request that the vials of frozen eggs be thawed in the laboratory and be discarded.

Note: Autologous eggs only require the initials/signature of the person whom the eggs were removed.

Donor samples require the partner signature, if applicable.

I. Choose one of the two options below (one sample type per consent):

A. Autologous eggs (Produced in own body) _____
Patient's Initials

B. Donor Sample (Donated or Purchased) _____ _____
Patient's Initials Partner's Initials (if applicable)

Please list the egg donor identification code for the vials you wish to discard: _____

_____

II. Choose one of the two options below regarding the number of vials of eggs to be discarded:

A. I/We desire that **ALL** vials of my/our frozen eggs stored at Boston IVF be discarded.

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

B. I/We desire that **ONLY** eggs frozen on **the following dates** be discarded (List): _____
(MM/DD/YYYY)

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

By signing this document, I/we acknowledge that our Boston IVF physician and caregivers have obtained from me/us informed consent to proceed with discarding my/our frozen eggs. I/We release the physicians, nurses, technicians, and other Boston IVF staff from any responsibilities regarding eggs after they are discarded.

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

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BOSTON IVF

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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BOSTON IVF

Notarization Form (This form is only needed if not able to have witnessed at Boston IVF)

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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