

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 treatment using donor sperm. 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.

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)**

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)