



CONSENT TO DISCONTINUE STORAGE OF EMBRYOS

Chart # _____

We, _____ and _____
(Please print name) (Please print name)
of, _____

(Address)

I/We currently have embryos cryopreserved at the Regional Fertility Program (RFP). I/We acknowledge that I/we have previously received, read and understood written information on embryo cryopreservation and storage. I/We have had the opportunity to ask any questions which have been answered to my/our satisfaction. We can **only accept the original document.** PLEASE DO NOT FAX OR EMAIL.

I/We wish to discontinue storage of my/our embryos. I/We request that they be used in the following manner (choose **ONE** and initial):

- Discarded _____ | _____
(patient) (partner)
- Used for improving or providing instruction in Assisted Human Reproduction procedures* _____ | _____
(patient) (partner)

*Such activities are essential to improve clinical care at the Regional Fertility Program. These activities will never involve the transfer of eggs or embryos to another person or cloning. If future laws prohibit such use of embryos, or if too many embryos are already designated for such use as determined by the RFP, the excess embryos may be discarded

- I/We agree to be contacted in the future regarding **potential** use of my embryo(s) for research. My/our embryo(s) will **not** be used for research without my explicit consent. _____ | _____
(patient) (partner)

Occasionally, embryos may be eligible for use in research. Research differs from improving or providing instruction in Assisted Human Reproduction Procedures in that it often involves trying to answer a question through experimentation. Research on embryos can only be done with explicit consent. If future laws prohibit such use of embryos, or if too many embryos are already designated for such use as determined by the RFP, the excess embryos may be discarded.

- Donated for future use by another couple/patient^ _____ | _____
(patient) (partner)

^Not all embryos are eligible for our embryo donation program. Currently, for embryos to be considered for anonymous donation at the Regional Fertility Program, the eggs used to create them must have been retrieved prior to age 38 years. In general, if ICSI was performed for severe male factor infertility, these embryos are not eligible for anonymous donation. Individuals wishing to anonymously donate embryos for the reproductive use of another must complete required infectious diseases screening, complete a questionnaire including information about physical characteristics, education, ethnicity, medical and family histories, and undergo psychological assessment.

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^By selecting this option, I/we consent to contact by RFP to determine eligibility of embryo(s) for donation. If infectious diseases screening is positive, or any part of the required screening is incomplete (including by reason of failure to maintain contact with the RFP), or if embryos are not accepted for our donor program for any other reason, another disposition must be selected. If another disposition is not selected, or if future laws prohibit donation of embryos, or if a suitable recipient cannot be found after reasonable time and effort has been spent by the RFP, the embryos may be discarded.

I/We understand that I/we may withdraw my/our consent by notifying RFP in writing.

Patient: _____
Print Name Signature

Partner: _____
Print Name Signature

Witness: _____
Print Name Signature

Date: _____
(yyyy/mm/dd)

In no way does your consent waive your legal rights, nor does it release the staff or the Regional Fertility Program from their professional and legal responsibilities. Your continued participation should be as informed as your initial consent. Please feel free to ask for clarification or new information throughout your participation. If you have further questions at any time, please contact us at (403) 284-5444. You may receive copies of this and accompanying forms upon request.