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.

_____ If FDA donor eligibility determination was completed, donate the frozen oocytes to an individual. Name of the individual:_____by date of: _____
Laboratory to which oocytes will be sent:
Address:_____Phone number: _____

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. I agree that any recipient receiving oocytes, which I have donated to Emory in this manner, may regard the donated oocytes as resultant in 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 and all expenses associated with thetransfer.

I, Patient, attest that these instructions concerning 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.

_____	_____	_____
Signature of Patient	Date	Time
_____	_____	_____
Signature of Staff Member	Date	Time
OR		
_____	_____	_____
Print Name of Notary Signature of Notary	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, or mailed to Emory at the address below. Alternatively, the Patient may sign this form in the presence of an Emory Reproductive Center staff member with a state-issued ID.

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