Consent to Discard

I/We have:

Patient/Partner Initials

_____ / _____ Embryo(s) that I/we wish to discard
These are from (*check one*): ☐ Self ☐ Donor Code(s): _____
☐ Abnormal PGS/PGD

_____ / _____ Sperm vial(s) that I/we wish to discard
These are from (*check one*): ☐ Self ☐ Donor Code(s): _____

_____ / _____ Oocyte(s) that I/we wish to discard
These are from (*check one*): ☐ Self ☐ Donor Code(s): _____

_____ / _____ Tissue(s) that I/we wish to discard
These are from (*check one*): ☐ Self ☐ Donor Code(s): _____

I/we _____ and _____ no longer want the cryopreserved material maintained in storage. Please **thaw and discard** material according to the Regional One Health's policies, including the State of Tennessee and Federal Government guidelines. **Note:** Regional One Health will discard frozen material within 10 days from receipt of this consent unless a written and signed letter of revocation is received within those 10 days.

If donor tissue was used and/or cryopreserved, I/we warrant that I/we have no other contractual obligation to the donor that conflicts with the intentions in this consent.

This Consent to Discard must be notarized for the protection of you, UT Regional One Health Physicians, Inc., Regional One Health, and the tissue. After signatures and notarization are obtained, please bring, mail, fax, or email this consent to: Lucy Williams, Embryology Laboratory Director (ljwilliams@ut-rop.org), fax: (901) 515-3199.

_____ _____
Patient Signature Date Partner Signature Date

_____ _____
Patient Printed Name Partner Printed Name

[Notary Page to follow]

Affix Patient Label

Patient's Initials _____
Partner's Initials _____

Consent to Discard

[Notary Page for: Consent for Frozen/Thawed Embryo Transfer]

STATE of _____)
) :SS
COUNTY of _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, referred to in this consent form as "Patient".

My commission expires: _____ .

_____
Notary Public

STATE of _____)
) :SS
COUNTY of _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, referred to in this consent form as "Partner".

My commission expires: _____ .

_____
Notary Public

Affix Patient Label

Patient's Initials _____
Partner's Initials _____