

Female Patient Name:

SS#/ Driver's License#:

Spouse/Partner Name:

SS#/ Driver's License#:

New England Fertility Institute

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AUTHORIZATION FOR DISPOSITION OF UNFERTILIZED OOCYTES, ABNORMALLY FERTILIZED OOCYTES AND NON-VIABLE OR POOR QUALITY EMBRYOS

I/we _____ and _____
Patient (Printed Name) Partner (Printed Name)

indicate below our decision for disposition of unfertilized egg(s), abnormally fertilized egg(s), and non-viable or poor quality embryos.

This decision is made with my/our understanding that the actions necessary for executing my/our decision will be made by the personnel of New England Fertility Institute IVF Laboratory following their evaluation of these egg(s) and embryos. Some eggs may not fertilize during in vitro fertilization. Additionally, some eggs may become fertilized by more than one sperm (abnormal fertilization). Furthermore, it has been explained to me/us that following fertilization the development of the embryo(s) may arrest and therefore become non-viable and/or are of too poor quality to support cryopreservation.

I/we certify that I/we know of no other individual with any rights or claims with respect to these embryos and hereby discharge New England Fertility Institute and affiliated physician(s) of any responsibility of their disposition.

I/we acknowledge and agree that these embryos as indicated herein, may be disposed of by New England Fertility Institute IVF Laboratory Personnel pursuant to the directives contained herein.

THIS CONSENT IS VALID FOR 1 YEAR AFTER SIGNING.

Patient (Printed Name) _____

Signature _____ Date _____

Partner (Printed Name) _____

Signature _____ Date _____