FERTILITY CENTERS OF ILLINOIS - "FCI"
AND GAMETE RESOURCES, INC. - "GRI"
CONSENT TO DISCARD CRYOPRESERVED EMBRYOS

(For Office Use:
Apply Patient Label Here)

Print Patient's Full Name	Date of Birth	SS #

Print Partner's Full Name	Date of Birth	SS#

I/We, being the rightful and legal owners of the embryos specified herein and hereafter referred to as the "Embryos", no longer wish to retain these Embryos for my/our own use in attempting to establish a pregnancy.

I/We have considered the alternative of releasing my/our embryos to an outside embryo donation agency (**Consent #4)** donating my/our embryos to research (**Consent # 32**) or releasing my/our embryos to a long-term storage facility (**Consent #4**) and find each to be unacceptable.

For Lab Use Only

The Embryos currently in cryogenic storage at the "FCI AND GRI" are identified as follows:

Date of Cryopreservation (Printed on Vessel Housing Specimen) (Month, Date, Year)	Embryo ID Number (Printed on Vessel Housing Specimen)	Name (Printed on Vessel Housing Specimen)
_____,		
_____,		
_____,		

Straws Cryopreserved:_____ Straws Thawed:_____ Straws remaining cryopreserved at "FCI AND GRI":_____

The specimen(s) has been identified unequivocally by: "FCI AND GRI" Representative Signature & Title:

_____

Initial Only If You Agree

Patient (please initial) _____ Partner (please initial) _____

I/We wish to release my/our cryopreserved embryos to the "FCI AND GRI" to utilize in staff training and/or development. They will not be used to establish a pregnancy.

Please Initial Your Choice

Patient (please initial) _____ Partner (please initial) _____

I/We hereby authorize a "FCI AND GRI" staff member to remove the Embryos specified above from cryogenic storage. I/We understand that a 60-day waiting period is required from receipt of this consent by the "FCI AND GRI" until the time these Embryos are actually discarded.

OR

Patient (please initial) _____ Partner (please initial) _____

OR

Either or both of us will confirm the identity of these Embryos specified above and remove them from cryogenic storage.

Please Initial Your Choice

Patient (please initial) _____ Partner (please initial) _____

I/We wish to receive written confirmation that the Embryos specified above have been discarded.

OR

Patient (please initial) _____ Partner (please initial) _____

OR

I/We <u>do not</u> wish to receive confirmation following the discard procedure.

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(For Office Use:
Apply Patient Label Here)

Patient Section

Patient Signature	Patient Signature	Date
	Patient Printed Name	
For Notary/Witness Use Only	Signature of Notary/Witness for Patient	Date
	Printed Name and Title for Notary/Witness for Patient	
Notary Stamp for Patient's Signature		

Partner Section (if applicable)

Partner Signature	Partner Signature	Date
	Partner Printed Name	
For Notary/Witness Use Only	Signature of Notary/Witness for Partner	Date
	Printed Name and Title for Notary/Witness for Partner	
Notary Stamp for Partner's Signature		

Consents signed outside the practice must be notarized and dated. BOTH partners (as applicable) MUST sign this consent.

Please Keep a Copy and Mail Original to:

Cryovault, Inc.
P.O. Box 136
Highland Park, IL 60035

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