Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

DISCARD CONSENT

I/We have participated in a program at Lucile Salter Packard Children's Hospital at Stanford ("Stanford") in which reproductive tissues, in the form of embryo(s), oocyte(s) and/or sperm, as indicated below, were cryopreserved for later use in attempting to initiate a successful pregnancy. I/We no longer wish to retain these reproductive tissues for my/our use in attempting to establish a pregnancy and desire to discard my/our reproductive tissues, as set forth below.

I/We no longer desire to retain for use in attempting to establish a successful pregnancy the following reproductive tissues:

_____ _____ Embryo(s)
Patient Initials Partner Initials

_____ Oocyte(s)/ovarian tissue
Patient Initials

_____ Sperm/testicular tissue
Patient Initials

I/We have considered the alternatives of donating reproductive tissues to another individual or couple for the purpose of attempting to establish a pregnancy, or donating the reproductive tissue for approved scientific research, or retaining these embryos/oocytes and/or sperm indefinitely in cryogenic storage and find each to be unacceptable.

The reproductive tissues are currently cryogenically preserved at Stanford. I/We hereby direct Stanford to discard the reproductive tissues as follows:

_____ _____ All reproductive tissues indicated above that are currently cryogenically preserved at Stanford
Patient Initials Partner Initials

OR

_____ _____ Only reproductive tissues indicated above from the following creation or collection date(s):_____
Patient Initials Partner Initials

CONSENT TO PERMANENT DISPOSAL (DISCARD) OF CRYOGENICALLY PRESERVED EMBRYOS/OOCYTES/SPERM

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

I/We have had the opportunity to discuss my/our decision to discard the reproductive tissues specified herein and understand that removal of these reproductive tissues from cryogenic storage will render them non-viable and therefore no longer available for the purpose of attempting to establish a pregnancy. I/we understand that my/our decision to discard the reproductive tissues is a final decision that cannot be revoked at a later date.

I/We hereby authorize a Stanford staff member to remove the reproductive tissues indicated above from cryogenic storage, thaw without further intervention and, thereafter, to dispose of them permanently.

Date	Time	Patient Signature	Patient Name	Patient DOB
Date	Time	Partner Signature	Partner Name	Partner DOB

(Please note: Consents signed in clinic must be witnessed by an unrelated Stanford staff member. Consents signed outside Stanford require notarization before return. ***BOTH*** *partners (as applicable)* ***MUST*** *sign this consent.)*

AS REQUIRED BY CALIFORNIA LAW, THE ORIGINAL OF THIS CONSENT SHALL BE KEPT IN YOUR MEDICAL RECORD AND A COPY PROVIDED TO YOU FOR YOUR RECORDS. THIS IS AN IMPORTANT DOCUMENT AND SHOULD BE RETAINED WITH OTHER VITAL RECORDS.

Witness:

Witness Name

Date

Witness Signature

WITNESS ACKNOWLEDGEMENT:

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of_____)

On_____before me, _____

(Date) (insert name and title of officer)

personally appeared_____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____(Seal)

WITNESS:

_____	_____	_____	_____
Date	Time	Signature	Print Name