We, _________________________ (Patient) and __________________________ (Partner), hereby direct the Massachusetts General Hospital Fertility Center, in accordance with its policies and procedures, to dispose in the following way of all embryos currently being cryopreserved for us. We understand that this is a final decision. These signatures need to be witnessed by an IVF staff member or a notary public.

This Consent to Disposition reflects new state law, and in the event of any question or conflict with the terms of prior consent forms that we signed, this Consent to Disposition supersedes any prior form.

Disposition of Cryopreserved Embryos:
We hereby make the following decision regarding the final disposition of frozen embryos that have been stored and that we will not use for fertility purposes. Please choose one of the three options and initial it.

A. Transfer: We (Patient and Partner) will arrange for transfer of remaining embryos to another facility for storage or possible donation to another person.

B. Research or Activities Related to Improving Assisted Reproductive Therapies (ART):

- The research and activities related to improving ART may include, for example, studies of ways to improve techniques or fertility success rates or studies that may improve our understanding of infertility and reproductive medicine.

- The research also may include embryonic stem cell research. In this case, MGH would contact us to provide more information about a particular study and to ask whether or not we consent to donate embryos to the study. MGH would retain a link between my/our embryos and limited information about me/us in order to recontact us about such research at a future time.

C. Discard: We would like the embryos to be discarded.

Patient: ___________________________      ___________________________ Date: ______
Signature                                Print Full Name

Partner: ___________________________      ___________________________ Date: ______
Signature                                Print Full Name

Witness: ___________________________      ___________________________ Date: ______
Signature of IVF Staff                   Print Full Name
- OR -

Notary Public: ________________________      ___________________________
Signature                                Print Full Name
My Commission Expires: ___________________