



**MASSACHUSETTS
GENERAL HOSPITAL**
FERTILITY CENTER

Patient Name: _____

Partner Name: _____

Date of Birth: _____

Date of Birth: _____

MRN: _____

MRN: _____

Embryo Disposition Consent

I/we, _____ (Patient), and _____ (Partner, if applicable) hereby direct the Massachusetts General Hospital Fertility Center, in accordance with its policies and procedures, to the disposition of embryo(s) as indicated below. I/we understand that this is a final decision. **Signatures must be witnessed by an MGH IVF staff member or notary public.**

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

I/we hereby make the following decision regarding the final disposition of frozen embryos that I/we no longer wish to have stored for fertility purposes at the Massachusetts General Hospital.

Initial only one disposition option below (A, B, or C):

Disposition Options	Patient Initials	Partner Initials (if applicable)
A. Export: I/we will arrange for transport of Embryo(s) to another facility.		
B. Discard: I/we would like to discard Embryo(s) as indicated below.		
C. *Donate: I/we would like to donate Embryo(s) to Research or Activities Related to Improving Assisted Reproductive Therapies- (described below).		

Indicate which embryo(s) are to be exported, discarded, or donated:

_____ **ALL** embryo(s) stored at MGH

_____ **ONLY** the following embryo(s) stored at MGH _____

*This may include studies of ways to improve techniques or fertility success rates or studies that may improve our understanding of infertility and reproductive medicine. The research may also include embryonic stem cell research; in this case, MGH would contact you to provide more information about a particular study and to ask whether or not you 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.

Patient:

Partner (if applicable):

Date: _____ DOB: _____

Date: _____ DOB: _____

Patient Name: _____

Partner Name: _____

Patient Signature: _____

Partner Signature: _____

MGH Staff printed name: _____

MGH Staff printed name: _____

MGH Staff Signature: _____

MGH Staff Signature: _____

NOTARY (required if not witnessed by MGH staff)

NOTARY (required if not witnessed by MGH staff)

County of _____ On this _____ day of _____, 20 _____, before me the undersigned notary public, personally appeared _____, provided to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

County of _____ On this _____ day of _____, 20 _____, before me the undersigned notary public, personally appeared _____, provided to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

Notary Signature: _____

Notary Signature: _____

Date: _____ Commission Expiration Date: _____

Date: _____ Commission Expiration Date: _____

(Seal)

(Seal)