

**Consent for the Disposal of Cryopreserved Embryos**

We, \_\_\_\_\_ and \_\_\_\_\_,  
(Patient Name and Date of Birth) (Partner Name and Date of Birth)

currently have embryos cryopreserved and stored at Strong Fertility Center. We now wish to dispose of the following embryos,

- Genetically Tested, Normal Embryos**
- Genetically Tested, Abnormal Embryos (Non-Transferable: High Level Mosaic, Aneuploid, Complex Aneuploid, and/or Affected)**
- Genetically Tested, Abnormal Embryos (Potentially Transferable: Low Level Mosaic, Chaotic, Non-informative, and/or Carrier)**
- No Result Embryos**
- Untested Embryos**
- ALL Embryos**

**Special Instructions:** \_\_\_\_\_

We understand that the alternatives to disposal are continued storage of the embryos, thaw/use of embryos that are suitable for transfer in an attempt to create a pregnancy, or donation of embryos to the lab or to another infertile couple, none of which we wish to do.

Patient Name: _____
Patient Signature: _____
Notary Public: _____
Date: _____
<i>Notary Stamp</i>
<div style="border: 1px solid black; width: 100%; height: 80px;"></div>
<b>OR</b>
SFC Staff Witness Name: _____
SFC Staff Title: _____
SFC Staff Signature: _____

Patient Name: _____
Patient Signature: _____
Notary Public: _____
Date: _____
<i>Notary Stamp</i>
<div style="border: 1px solid black; width: 100%; height: 80px;"></div>
<b>OR</b>
SFC Staff Witness Name: _____
SFC Staff Title: _____
SFC Staff Signature: _____