Disposal of Gametes or Embryos

**These template documents were revised before the US Supreme Court decision in *Dobbs v. Jackson* (which repealed Roe v. Wade), and therefore, SART has not reviewed the template documents and did not make any changes based on the *Dobbs* decision. SART strongly recommends that before any SART template document is put into use in a Member's practice, the document should be reviewed by the Member's local legal counsel to ensure that the language conforms to current federal, state and local laws as these may have recently changed or are in the process of being changed.**

DESCRIPTION

This document, signed by the patient(s), instructs the laboratory to discard certain eggs, sperm or embryos.

TARGET

* All patients intending to have their eggs, sperm, and/or embryos discarded

RELEASE NOTES

* This is the 2nd version of this document
* Signature page allows for Witness as well as Notary verification

TO DO

* Modify this document according to local needs and preferences
* Replace THE CLINIC with clinic name
* Get legal review to assure conformance with State and local laws and regulations

***DISCLAIMER.***

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Instruction to Dispose of

Specific Frozen Materials

**Patient Depositor/Partner A: D**ate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Depositor/Partner B:** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We (I) request that THE CLINIC dispose of our (my) frozen material named below (please check box as applicable) that were frozen and/or placed in storage at THE CLINIC on or about \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date):

** Frozen embryo(s)**

*(Requires names and signatures of both members of the couple who signed the original cryopreservation consent)*

** Frozen oocytes (eggs) and/or ovarian tissue**

*(Requires female depositor name and signature only)*

** Frozen sperm, epididymal and/or testicular tissue**

*(Requires male depositor name and signature only; Partner name requested)*

** Frozen donor sperm**

*(Requires intended female recipient name and signature only)*

** Frozen donor oocytes (eggs)**

*(Requires names and signatures of intended parents who purchased donor oocytes for their use)*

*Limited use for training before discard?  Yes  No*

This disposal consent form gives permission to stop cryopreservation and dispose of frozen material. Permission must be obtained from specific persons depending upon the type of cryopreserved material:

* Embryos created by depositor or donor gametes requires the signature of both members of the couple who signed the original embryo cryopreservation consent.
* Oocytes (eggs) and/or ovarian tissue require the signature of the female depositor.
* Sperm, epididymal and/or testicular tissue requires the signature of the male depositor.
* Donor sperm requires the signature of the intended female recipient
* Donor oocytes (eggs) requires the signature of intended parents who purchased donor oocytes for their use.

Frozen materials from a known donor (eggs, sperm or embryos), requires the signatures of both recipients of these materials, as well as copies of the agreements and/or consents granting recipients the frozen material. This must be provided along with this consent form, and any disposition choice must agree with those documents.

We (I) understand, agree and consent that, after proper completion of this form the frozen embryos, sperm, epididymal and/or testicular tissue or oocytes (eggs) will be discarded according to the Ethical Guidelines of the American Society for Reproductive Medicine. These frozen materials will no longer be available for any use, including: 1) in any assisted reproductive technology (ART) or other fertility treatment or procedure; and 2) for any genetic testing or data collection.

*Limited Use Before Discard.* Before discarding any frozen material, it is possible to de-identify the material and use it for clinical training purposes in the embryology laboratory. Material would not be used to try to create a pregnancy. All material used for this limited purpose would ultimately be discarded according to ASRM Ethical Guidelines We (I) understand the limited use of frozen material after thaw and de-identification, and indicate our choice below:

 We (I) consent to using my/our frozen material for training.

 We (I) do not consent to using my/our frozen material for training.

We (I) further understand and agree that we are responsible for paying for all applicable storage fees until a properly executed version of this consent is received by THE CLINIC.

*Confidentiality.* We (I) understand the confidentiality of medical records, including any photographs, will be maintained in accordance with applicable state laws.

# We (I) have had the opportunity to ask any questions we (I) might have and those questions have been answered to our (my) satisfaction. Any further questions may be addressed to THE CLINIC. We (I) acknowledge that disposal is being performed at our (my) request and with our (my) consent.

*Please refer to the above for required signatures. This form must be signed in person and witnessed at THE CLINIC, or EACH signature must be NOTARIZED using the attached form. Please do not sign this form in advance.*

We (I) hereby instruct the laboratory to thaw and discard the frozen material indicated above:

*If signed out of the office:*

X

Patient Depositor/Partner A Signature Date

Printed Name Date of Birth

**Notary Public**

Sworn and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_.

Notary Signature Date

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X

Patient Depositor/Partner B Signature Date

Printed Name Date of Birth

**Notary Public**

Sworn and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_.

Notary Signature Date

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*If signed in the office:*

**Statement by Witness (must be employee of THE CLINIC and at least 18 years of age)**

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_