wisconsin fertility INSTITUTE

CONSENT TO DISCONTINUE STORAGE OF CRYOPRESERVED HUMAN EMBRYOS

We, _____and _____ ("Patient" and "Partner") have one or more cryopreserved embryos currently stored by Dr. David Olive and/or Dr. Elizabeth Pritts, his/her associates and/or assistants at the Wisconsin Fertility Institute located at 3146 Deming Way Middleton, WI. By executing this document, we freely and affirmatively (please check appropriate box):

- ☐ Provide notice of our desire to have all of our Embryos disposed of in the manner deemed appropriate by my physician according to medically accepted standards. **We understand that disposal of our Embryos will result in their destruction.**
- ☐ Provide notice to my physician of our desire to donate embryos for the purpose of causing a pregnancy in an anonymous embryo recipient.
- ☐ Provide notice to my physician of our desire to donate embryos for the purpose of scientific research.
- ☐ Provide notice to my physician to have our embryos transferred to a long-term storage facility.

We execute this Consent knowingly and voluntarily, and therefore, anticipate no physical or psychological risks as a result of this matter.

In addition to and in furtherance of the above, we release the PRACTICE, and its doctors, employees, agents, and representatives from any and all liability and responsibility of any nature whatsoever for their conduct pursuant to this Consent and for any adverse consequences which might arise in connection with this matter.

In signing this document, we certify that: (1) we have read and understand all of the information in this document, (2) we have been given an opportunity to ask any questions we have about this matter and have had our questions answered in a manner satisfactory to us; (3) **we understand that this Consent is IRREVOCABLE**; and (4) we have been given a copy of this document.

Patient Signature: _____ Print Name: _____

Partner Signature: _____ Print Name: _____

NOTARIZATION REQUIRED

The above named Patient _____ and Partner_____, appeared before me this _____day of _____20____, and acknowledged their signatures on this document.

Notary Public_____ County & State of_____.

Signed:_____ My commission expires:_____

Office Use Only

Lab Director Initials:_____ Witness Initial:_____ Date_____

3146 Deming Way Middleton WI 53562 608-824-0075