## Strong Fertility Center 500 Red Creek Dr., Suite 220, Rochester, NY 14623 585-487-3378

## CONSENT TO DONATE FROZEN EGGS

<u>-,</u>	
I,(Name) my intent to donate all of my frozen, stored oocy	
the University of Rochester. I understand that as	of the date below, I will no longer have
access to my frozen oocytes or be responsible for	r paying any storage fees. My oocytes will
only be used for training and quality control pur	poses and then discarded according to
standard laboratory protocol. They will NOT be	used to create a pregnancy.
Patient Signature:	Date:
Notary Public:	Date:
OR	
OK	
SFC Witness:	Date:
Witness Printed Name/Title:	