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

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**,** hereby designated by an "X" or a checkmark in the appropriate box(es), according to established laboratory protocol:

- **[ ] 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: ____________________________

Notary Stamp

OR

SFC Staff Witness Name: ___________________

SFC Staff Title: ____________________________

SFC Staff Signature: ________________________

Patient Name: ____________________________

Patient Signature: __________________________

Notary Public: ____________________________

Date: ____________________________

Notary Stamp

OR

SFC Staff Witness Name: ___________________

SFC Staff Title: ____________________________

SFC Staff Signature: ________________________