Oregon Reproductive Medicine

Authorization to Discard

(Removal of cryopreserved Embryo(s) from storage, Resulting in Non-Viability, and Disposal by ORM)

This form is used to request that ORM remove Embryos from storage, resulting in non-viability, and dispose of the Embryos. This form must be signed by the individual or individuals who have the authority to do so. Most often, this means the intended parents.

Notice: ORM currently stores cryopreserved embryos on behalf of the below-named individual(s) (the "Embryos"). Embryos are removed from storage in liquid nitrogen. Once they have been removed from storage the temperature rises, the embryo(s) thaw and if they are not placed immediately in appropriate thawing media the cells are no longer viable. By filling out this form, you are requesting that the lab staff at ORM discard the Embryos. Discarding the embryos means they will irretrievably be unavailable for use in treatment and will not result in pregnancy.

Acknowledgment: We/I, the below-named individual(s) have discussed this decision with our/my healthcare provider. We/I have asked, and received satisfactory answers to any questions we/I may have had regarding this decision and the method of disposal of the Embryos. We/I understand there are alternatives to having the Embryos disposed of and we/I have considered those alternatives and decided to move forward with this request freely and voluntarily.

Request and Authorization:
Intended Parent Name: _____
Date of Birth: _____

Intended Parent Partner Name: _____
Date of Birth: _____

We/I the above named individual(s), are/am requesting that all Embryos held by Reproductive Medicine Laboratory, Inc. and Oregon Reproductive Medicine, LLC (referred to together as "ORM") on our/my behalf (the "Embryos") be disposed of by ORM. We/I am/are authorize ORM to take the action specified in this request.

Intended Parent Signature: _____ Date: _____
Print Name: _____

Partner Signature: _____ Date: _____
Print Name: _____

State of _____)
)ss.
County of _____)

Signed or attested before me on _____ by _____
(Date) (Name(s) of Person(s))

_____
(Notary Signature)

Notary Public – State of _____ My Commission Expires: _____

Lab use only; Date discarded: _____ # of embryos discarded: _____
Embryologist: _____ Date: _____
Witness: _____ Date: _____