

**CONSENT TO DESTROY/DONATE CRYOPRESERVED PRE-EMBRYOS  
 STORED AT THE VIRGINIA IVF AND ANDROLOGY CENTER**

I/We, \_\_\_\_\_ (woman, referred to as "Patient") (PRINT FULL LEGAL NAMES),

and \_\_\_\_\_ (partner, referred to as "Partner") hereby request that the Virginia IVF and Andrology Center destroy/donate all of my/our stored cryopreserved pre-embryos as indicated by my/our initials below. I/We understand that this completed form must be *notarized* and mailed to Virginia IVF and Andrology Center, 9030 Stony Point Parkway, Suite 390, Richmond, VA 23235. I/We understand that upon receipt of this completed form the Virginia IVF and Andrology Center will no longer charge me/us for the storage of my/our cryopreserved pre-embryos. **(both Patient and Partner, (if any), must agree to, and indicate, the same election, and only one election can be selected):**

*Patient's    Partner's*  
*Initials    Initials*

- \_\_\_\_\_    \_\_\_\_\_    Virginia IVF and Andrology Center to terminate the cryopreservation and dispose of the thawed pre-embryos according to its practice.
  
- \_\_\_\_\_    \_\_\_\_\_    Donate the pre-embryos to the Virginia IVF and Andrology Center for research, following which any remaining pre-embryos will be disposed of according to the practice of Virginia IVF and Andrology Center.
  
- \_\_\_\_\_    \_\_\_\_\_    Donate the pre-embryos to an anonymous recipient(s) for the purpose of assisted conception. In selecting this option, I/we agree to release any rights or claims to any resulting child(ren). I/we also agree to fill out a profile form that will provide prospective recipient couples with anonymous general information about me/us and my/our medical histories. If appropriate recipients are not found, or if my/our pre-embryos are found to be unsuitable for donation, Virginia IVF and Andrology Center will terminate cryopreservation and dispose of the pre-embryos according to the then current practice of Virginia IVF and Andrology Center.
  
- \_\_\_\_\_    \_\_\_\_\_    Donate the pre-embryos to a known recipient(s) whose name(s) is/are: \_\_\_\_\_  
 By selecting this option, I/we understand that it will be necessary for me/us to undergo further medical and genetic screening, and to seek independent legal assistance for this directed donation.

Patient's Signature	Social Security Number	Date
Partner's Signature	Social Security Number	Date
<b>Notary Signature</b>	Date	Commission Expires

**For VA-IVF & Andrology Center Use Only**

Date Received: _____	Received By: _____	VA-IVF employee signature
Date Destroyed _____	Embryologist:: _____	Verified: _____
VA-IVF embryologist signature		VA-IVF employee signature
Date Donated _____	Embryologist:: _____	
VA-IVF embryologist signature		