Duke Fertility Center

REQUEST FOR TERMINATION OF FROZEN EMBRYO STORAGE

We _____, Duke Medical Record Number _____
and _____, Duke Medical Record Number _____
request that the cryopreserved EMBRYO specimens collected and stored in our name be removed from storage at Duke Fertility Center and destroyed.

This request applies to the following specimen(s):

DISCARD THE FOLLOWING EMBRYOS

Date(s) Frozen:	# of embryos to discard:

Please list the best two phone numbers where you can be reached if we have any questions.
1. _____ 2. _____

PLEASE NOTE: Both partner's signatures are mandatory and must EITHER be signed in the presence of a Notary Public OR be witnessed by a member of the Duke Fertility Center Laboratory Staff.

Patient Name (print) _____
Signature _____ Date _____

State of _____
_____ County
Sworn to and subscribed before me this
the ____ day of _____, 20____
Notary Public _____

Witness _____
Duke Fertility Center Lab Staff Only – signature
Name (print) _____ Date _____

Partner Name (print) _____
Signature _____ Date _____

State of _____
_____ County
Sworn to and subscribed before me this
the ____ day of _____, 20____
Notary Public _____

Witness _____
Duke Fertility Center Lab Staff Only – signature
Name (print) _____ Date _____