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 GENETICALLY TESTED EMBRYOS

DATE FROZEN	EMBRYO ID	DIAGNOSIS	DATE FROZEN	EMBRYO ID	DIAGNOSIS	DATE FROZEN	EMBRYO ID	DIAGNOSIS

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 _____