ColumbiaDoctors
Columbia University Fertility Center
5 Columbus Circle PH Floor New York NY 10019 P: 212-314-8809 Fax: 212-314-8801 Email: fertility-lab@cumc.columbia.edu

Dear Patient(s),

Attached are the cryopreservation disposition forms you requested. Please read the following instructions carefully to facilitate completing this consent accurately.

Your consent must be signed in the presence of a notary. Alternatively, you have the option of scheduling an appointment to sign your disposition consent in the presence of Columbia University staff. **This must be a scheduled appointment.** Please email, fertility-lab@cumc.columbia.edu or call (212-314-8811 or 8809) to schedule disposition consent and leave a detailed message.

The following four (4) consent forms represent the disposition choices available; please notarize the form that represents your disposition choice.

- **Return only the form** that corresponds to the disposition option you choose.
  Make a copy of completed notarized forms for your own records and mail original to the address below.

- **Disposition forms that are incomplete or contain errors will be considered invalid and a new disposition consent issued (storage fees will apply until the consenting process is complete and approved**).

Consent Form 1- **Donate to another couple or person**

Consent Form 2- **Donate to research involving embryonic stem cells**

Consent Form 3- **Donate to research not involving embryonic stem cells**

Consent Form 4- **Discard**

Thank you,
Laboratory Team

Please send completed form to:

Attn: Embryology Lab
Columbia University Fertility Center
5 Columbus Circle PH
New York, New York 10019
See phone and email info above

Consent Form 1- Donate to another couple or person

- **We/I agree to donate our embryo(s) anonymously to another couple or person.** We/I relinquish all rights to and interests in any child or children resulting from the transfer of said embryos. We/I understand that in order to prevent transmission of infectious disease as required by the New York State Department of Health (NYS DOH), post cryopreservation blood tests are required (no charge to patients). Additional paperwork (simple questionnaire) and blood testing and can be arranged with a Donor Program representative. **The blood tests are a mandatory requirement from the NYS DOH and are required before the embryos can be donated and before further storage fees are discontinued.**

- **If the embryo(s) are not donated or eligible for donation, the CUFC laboratory staff can discard the embryo(s) without further consenting. We/I authorize the Columbia University CUFC laboratory staff to remove the embryo(s) from cryogenic storage for discard in our/my absence.**

Patient Print Name: ______________________________ **DOB**: ______________

Signature: ______________________________ **Date**: ______________

NOTARY State of ______________________ County of ______________________

On this ______________________ day of ______________________, 20______, before me personally

appeared______________________________ known to me (or satisfactorily proven) to be the person who

executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

____
Notary Public

Partner (*if applicable*) Print Name: ______________________________ **DOB:** ______________

Signature: ______________________________ **Date:** ______________

NOTARY State of ______________________ County of ______________________

On this ______________________ day of ______________________, 20______, before me personally

appeared______________________________ known to me (or satisfactorily proven) to be the person who

executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

____
Notary Public

CUFC Personnel use only

Witnessed by: Print Name ______________________________Date: ______________

Identification Used______________________________ Expiration Date______________

Tissue Bank Director: ______________________________ Date: ______________

<u>Consent Form 2</u>- Donate to research involving embryonic stem cells

- **<u>We/I choose to donate the embryo(s) for research involving embryonic stem cells</u>:** we/I understand that we/I have the right to withdraw our consent for the donation until the embryos(s) are actually used or until information that could link our/my identity to the embryo(s) is no longer retained.
- **We/I have been informed and agree to the following:** The embryo(s) may be used to derive embryonic stem cells for research; What would happen to the embryo(s) in the derivation of embryonic stem cells for research; The embryonic stem cells derived for the embryo(s) might be kept for many years; There will be no restriction/direction regarding the individual(s) who may receive medical benefits from the use of the embryonic stem cells; The research is not intended to provide direct medical benefit to us/me; The results of research using the embryonic stem cells may have commercial potential, but we/I will not receive financial or other benefits from any such commercial development; and the circumstances, if any, in which information that could identify us/me as the donor(s) would be available to researchers.
- **If the embryo(s) are not used in research or eligible for research, the CUFC laboratory staff can discard the embryo(s) without further consenting. We/I authorize CUFC laboratory staff to remove the embryo(s) from cryogenic storage for discard in our/MY absence.**

<u>Patient</u> Print Name: ____ **DOB**: ______________

Signature: ____ **Date**: ______________

<u>NOTARY</u> State of ____________________________County of ________________________________

On this ______________________________ day of _________________________, 20_____, before me personally

appeared____ known to me (or satisfactorily proven) to be the person who

executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

____
Notary Public

<u>Partner (*if applicable*)</u> Print Name: ____ **DOB:** ______________

Signature: ____ **Date:** ______________

<u>NOTARY</u> State of ____________________________County of ________________________________

On this ______________________________ day of _________________________, 20_____, before me personally

appeared____ known to me (or satisfactorily proven) to be the person who

executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

____
Notary Public

<u>CUFC Personnel use only</u>

Witnessed by: Print Name ____Date: ________________

Identification Used____ Expiration Date____________

Tissue Bank Director: ____ Date: ________________

Consent Form 3- Donate to research not involving embryonic stem cells

- **We/I agree that the embryo(s) may be used for research THAT DOES NOT INVOLVE EMBRYONIC STEM CELLS.** We/I understand that we/I have the right to withdraw our/my consent for the donation until the embryos(s) are actually used or until information which could link our/my identity to the embryo(s) is no longer retained. **We/I have been informed and agree to the following: embryos donated for research** might be kept for many years; the research is not intended to provide direct medical benefit to us/me.
- **If the embryo(s) are not used for research or eligible for research, the CUFC laboratory staff can discard the embryo(s) without further consenting. We authorize the Columbia University CUFC laboratory to remove the embryo(s) from cryogenic storage for discard in our/my absence.**

Patient Print Name: ______________________________ **DOB**: ______________

Signature: ______________________________ **Date**: ______________

NOTARY State of ______________________ County of ______________________

On this ______________________ day of ______________________, 20______, before me personally

appeared______________________________ known to me (or satisfactorily proven) to be the person who

executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

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Notary Public

Partner (*if applicable*) Print Name: ______________________________ **DOB:** ______________

Signature: ______________________________ **Date:** ______________

NOTARY State of ______________________ County of ______________________

On this ______________________ day of ______________________, 20______, before me personally

appeared______________________________ known to me (or satisfactorily proven) to be the person who

executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

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Notary Public

CUFC Personnel use only

Witnessed by: Print Name ______________________________Date: ______________

Identification Used______________________________ Expiration Date______________

Tissue Bank Director: ______________________________ Date: ______________

Consent Form 4- Discard

- **We/I agree to discard our/my cryopreserved embryo(s).**
- We/I understand that they will be destroyed and will no longer be available for use.
- We/I wish that our embryos be thawed with the express desire and intent that the thawing process leads to their degeneration.
- **We authorize the Columbia University CUFC laboratory staff to remove the embryo(s) from cryogenic storage for discard in our/my absence.**

Patient Print Name: ______________________________ DOB: ______________

Signature: ______________________________ Date: ______________

NOTARY State of ______________________County of ______________________

On this ______________________ day of ______________________, 20______, before me personally appeared______________________ known to me (or satisfactorily proven) to be the person who executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

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Notary Public

Partner (*if applicable*) Print Name: ______________________________ DOB: ______________

Signature: ______________________________ Date: ______________

NOTARY State of ______________________County of ______________________

On this ______________________ day of ______________________, 20______, before me personally appeared______________________ known to me (or satisfactorily proven) to be the person who executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

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Notary Public

CUFC Personnel use only

Witnessed by: Print Name ______________________________Date: ______________

Identification Used______________________________ Expiration Date______________

Tissue Bank Director: ______________________________ Date: ______________