DUKE FERTILITY CENTER
5704 FAYETTEVILLE ROAD
DURHAM, NC 27713
919.572.4673

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 there we any questions. Thank you!

__________________________ ________________________

PLEASE NOTE: Both partner's signatures are mandatory and <u>must</u> 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

____
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

____
Print Date

Revision date: 2/19/2016