KLINICKÉ CENTRUM ISCARE
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Declaration of permission to cryopreserved embryos treatment (disposal)

štítek/label

Name and surname: .....

Date of birth/national identity number (if assigned): .....

Patient identification number (if assigned): .....

ID document number: .....

Name and surname of patient partner/husband: .....

Date of birth/national identity number (if assigned): .....

Patient identification number (if assigned): .....

ID document number: .....

Patient and her partner/husband (infertile couple) have stored at the medical facility cryopreserved embryos. These were cryopreserved for their benefit, but were than not used for the purpose of IVF.
Patient and her partner/husband hereby declare, that they do not want to use these embryos for their further IVF.
Patient and her partner/husband therefore hereby give the medical facility the permission to dispose of these surplus embryos.
Patient and her partner/husband give the medical facility the permission to dispose (cross the selected option ☒):

☐ **all the surplus embryos they have stored at the medical facility,**
☐ **only the embryos cryopreserved after the IVF cyklus specified below:**
- specify the year and the month of the IVF cyclus in which the embryos were cryopreserved_____

By signing this document we confirm that we had a chance to read this declaration carefully and in good time, and ask the physician any related questions. Our questions were comprehensibly answered to our satisfaction. We have been informed that we may withdraw this declaration at any time. We declare that we have no further questions, we have understood the declaration well which we confirm by our signatures below.
This document is valid only if both patient and her partner/husband are identified with an identification document before signing this document in ISCARE a.s. or with the signatures approved by a legal authority.

Patient signature:

In _____date:

Patient partner / husband signature:

In _____date::

Member of the responsible staff, who performed the patient identification before signing this document in ISCARE a.s. (first name, last name and signature):

Member of the responsible staff, who performed the patient partner/husband identification before signing this document in ISCARE a.s. (first name, last name and signature):