CONSENT TO IVF-/ICSI- OR ICSI/TESE-TREATMENT

Patient:
Day of birth: _____
Name: _____

Partner:
Day of birth: _____
Name: _____

We request **Maigaard Fertilitetsklinik A/S** to perform fertility treatment by use of ART (Artificial Reproductive Technology).

We confirm that we have received verbal and/or written information about each step of the treatment, including the side effects and risks, which may rarely be associated with the treatment.

Declaration

We declare that:

☐ We are married

☐ We live in a marital relationship and commit to supporting the child until the age of 18

The child has the right to bear our surname and will have inheritance rights from both parents.
With our signatures below, we confirm that we are not genetically closely related (e.g. cousins)

Handling of Eggs and Sperm/Donor straws

If there are surplus fertilized eggs, we wish for them to be:

☐ Destroyed

☐ Frozen

In the event of the partner's death, we wish for:

☐ Destruction of eggs

☐ the woman to use the fertilized egg(s)

☐ Destruction of sperm/donor straw

☐ the woman to use sperm straws/donor straws

Choice of Treatment Plan

We wish for the following treatment option:

☐ 1 treatment

☐ Contract (woman max 43 years old) *Contract will be sent separately.*

Permission and Data Processing

With our signature, we give consent for information from a pregnancy scan to be shared with our general practitioner in Denmark.
This consent is valid as long as we, as a couple, are receiving treatment at **Maigaard Fertilitetsklinik A/S**.

_____
Date

_____ _____
Female signature Partner's signature

Our privacy policy can be read on: www.maigaard.dk