Maigaard
FERTILITETSKLINIK

CONSENT TO IVF- OR ICSI-TREATMENT

Patient:
Day of birth: ______________________________

Name: ____

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

I confirm that I 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.

Handling of Eggs

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

☐ Destroyed ☐ Frozen

Choice of Treatment Plan

I wish for the following treatment option:

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

Permission and Data Processing

With my signature, I give consent for information from a pregnancy scan to be shared with my general practitioner in Denmark.

This consent is valid as long as I'm being treated here at **Maigaard Fertilitetsklinik A/S** in consecutive treatments.

If the treatment involves the use of donor sperm, a statement concerning this must also be signed.

____
Date

____
Female signature

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

Maigaard Fertilitetsklinik A/S · www.maigaard.dk · mail@maigaard.dk · CVR-nr. 4149 5936
Jens Baggesens Vej 88 H · 8200 Aarhus N · Tlf. +45 86 10 13 88 · Fax +45 86 10 13 27
Jernbanegade 1, 3. sal · 5000 Odense · Tlf. +45 65 91 44 48