Maigaard
FERTILITETSKLINIK

STATEMENT OF CONSENT
TO THAWING OF FROZEN EMBRYO(-S)

We _____ and _____
Female name Partner's name

hereby consent that our frozen embryos are thawed and used in the treatment of our childlessness.

We hereby declare that …

- **we are married** ☐

- **we live together as partners and hereby recognize parenthood which implies a duty to provide for the child until the age of 18. The child will be entitled to bear the parents' name and have the right of inheritance after the parents** ☐

This consent form is valid 6 months from signed date and valid for all treatments with transfer of thawed embryos in this period.

_____
Date

_____ _____
Female signature Female Day of birth

_____ _____
Partner's signature Partner's Day of birth

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