Maigaard
FERTILITETSKLINIK

STATEMENT OF CONSENT
TO THAWING OF FROZEN EGGS

We, _____ and _____
Female name Partner's name

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

We confirm that we have received thorough oral and written information about the individual steps in the egg transplantation treatment, also including the ethical aspects, and about the side effects and risks which may in rare cases be associated with the treatment.

We hereby declare that …

- we are married
(enclose copy of marriage certificate if we have not received it before) ☐

- 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 eggs in this period.

_____
Date

_____ _____
Female signature Female Day of birth

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