Maigaard
FERTILITETSKLINIK

STATEMENT OF CONSENT
TO THAWING OF FROZEN EGGS

I _____

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

I confirm that that I 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.

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