

About this form

Who should fill in this form?

Fill in this form if:

- you or your partner are receiving treatment; **or**
- you are donating eggs, sperm or embryos; **or**
- you are storing your eggs or sperm to be used in future treatment.

If you are being treated together with your partner, both you and your partner have to fill in a copy of this form.

Why do I have to fill in this form?

There are a number of ways in which your clinic may want to use and share your information, either to:

- support your care and treatment, e.g. contacting your GP for your medical history
- to help them provide better services
- or for medical or other research

Under the Human Fertilisation and Embryology Act 1990 (as amended), you need to give your consent if you want identifying information about your or your partner's treatment, your donation or your storage to be shared with other non-HFEA-licensed people.

For example, if your clinic needs to contact your GP to get information about your past medical history, you need to give your consent so that they can explain to your GP why they need this

information. Your clinic cannot disclose any identifying information without this consent (other than in a medical emergency).

You can change or withdraw your consent at any time by asking your clinic for new forms.

Before filling in this form

Before you fill in this form, your clinic should make sure that you receive all the relevant information you need to make fully informed decisions.

They should make sure you understand:

- the implications of giving and placing restrictions on your consent; and
- the reasons why identifying information needs to be disclosed; and
- what identifying information may be disclosed and how it would be shared.

Why is there a declaration on every page of this form?

In case the pages of this form become separated, there is a page declaration on every page where you to sign to confirm that you have completed the page and fully agree with the consent and information given.

After filling in this form

After you have filled in this form, make sure that you receive a photocopy of it.

1 About you

1.1 **Your first name(s)** *Place clinic sticker here*

1.2 **Your surname**

1.3 **Your date of birth**

1.4 **Your NHS number**

For clinic use only

HFEA centre reference

Patient or donor number *Assigned to each patient or donor registered at clinic*

Partner's patient or donor number *if applicable*

Other relevant forms

2 About your partner

Only complete this section if you are receiving treatment with your partner

2.1 **Your partner's first name(s)** *Place clinic sticker here*

2.2 **Your partner's surname**

2.3 **Your partner's date of birth**

2.4 **Your partner's NHS number**

3 About your (or your partner's) treatment, donation or storage

*Everyone must complete this section, **except** if you are the partner of a woman receiving treatment using donor sperm or embryos created with donor sperm*

- 3.1 **Do you consent to identifying information about your or your partner's treatment, your donation or your storage being disclosed to:**
- any healthcare professional (to give the best medical care possible)
 - any administrative staff at your clinic, such as audit and accounts staff
 - your GP?
- Yes, all of the above ▶ *Go straight to question 3.2*
- No, only some of the above ▶ *Specify below who your information may be disclosed to*
- Any healthcare professional in any situation to give me the best medical care possible
 - Any administrative staff at my clinic, such as audit and accounts staff
 - My GP
- No, not to anyone (other than in a medical emergency) ▶ *Go straight to section 4*

Continues on the next page

Page declaration

Your signature

X

Date

For clinic use only

Patient or donor number

CD page 2 of 5

3 About your (or your partner's) treatment, donation or storage cont.

3.2 **Are there any other categories of people you would like your identifying information to be disclosed to?**

No ▶ Go straight to question 3.3

Yes ▶ Specify these categories below

3.3 **Do you have any restrictions that you would like to apply to your answers in this section?**

If donor eggs, sperm or embryos were used in your or your partner's treatment, it is presumed that you consent to this fact being disclosed to the people specified in question 3.1 and 3.2 unless you state otherwise below.

No ▶ Go straight to section 4

Yes ▶ Specify your restrictions below

4 About your status as partner or egg, sperm or embryo provider

Only complete this section if your partner is receiving treatment or you are donating eggs, sperm or embryos for the treatment of others.

When a woman consents to information about her treatment being disclosed, you can decide whether you want to be identified as the partner or the egg, sperm or embryo provider.

Continues on the next page

Page declaration

Your signature

Date

For clinic use only

Patient or donor number

CD page 3 of 5

4 About your status as partner or egg, sperm or embryo provider cont.

4.1 Do you consent to being identified as the partner or the egg, sperm or embryo provider as a result of information being disclosed about:

- your partner's treatment (if your partner is receiving treatment)?
- the treatment of others (if you are donating)?

Tick an answer in the column that applies to you.

Please note that if you are donating, your answer here does not affect the status of donors registered after April 2005. Identifying information about donors can still be disclosed to people born as a result of donation when they are aged 18 or older.

If your partner is receiving treatment

If you are donating

No, only on a need-to-know basis in a clinical emergency
▶ Go straight to section 5

No, only on a need-to-know basis in a clinical emergency
▶ Go straight to section 5

Yes ▶ Continue to question 4.2

Yes ▶ Continue to question 4.2

4.2 Do you have any restrictions that you would like to apply to your answer above?

No ▶ Go straight to section 5

Yes ▶ Specify your restrictions below

5 About medical or other research

5.1 Do you consent to identifying information about your or your partner's treatment, your donation or your storage being disclosed to medical or other researchers?

No ▶ Go straight to section 6

Yes ▶ Specify which activities they may use your information for

I consent to my information being disclosed for research that does not involve my direct participation (non-contact research)

I consent to minimal information being disclosed about me so that researchers can contact me for permission to use more information

I consent to minimal information being disclosed about me so that researchers can tell me about research and seek my consent to participate directly in research

Page declaration

Your signature

X

Date

For clinic use only

Patient or donor number

CD page 4 of 5

6

Declaration

Please sign and date the declaration

Your declaration

- I declare that I am the person named in section 1 of this form.
- I declare that:
 - before I completed this form, I was given information about the different options set out in this form; and
 - the implications of giving my consent, and the consequences of withdrawing this consent, have been fully explained to me; and
 - I understand that I can make changes to or withdraw my consent at any time.
- I declare that the information I have given on this form is correct and complete.
- I consent to the clinic (or any subsequent HFEA-licensed clinic that may become involved in my or my partner's treatment, my donation or my storage, or a data controller – as defined in section 1 of the Data Protection Act 1998) using the information on this form in the process of providing licensed activities (in accordance with the provisions of the Human Fertilisation and Embryology Act 1990, as amended), or for record storage and archiving purposes.
- I consent to the disclosure of information relating to section 5 of this form to the Human Fertilisation and Embryology Authority to enable it to comply with its statutory duties under the Human Fertilisation and Embryology Act (HFE) 1990 (as amended).

Your signature

Date

Page declaration

Your signature

Date

For clinic use only

Patient or donor number

CD page 5 of 5