



About this form

Who should fill in this form?

Fill in this form if:

- you or your partner are receiving treatment,
- you are donating eggs, sperm or embryos, or
- you are storing eggs, sperm or embryos for your or your partner's future treatment.

If you are being treated together with a partner, both you and your partner must 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 eg, 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 you, in relation to your or your partner's treatment, your storage or donation 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,
- 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?

There is a declaration on every page where you sign to confirm that you have completed the section or 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 have 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/CHI/passport number (please circle)**

For clinic use only

HFEA centre reference

Patient number *Assigned by clinic*

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/CHI/passport number (please circle)**

3 About your identifying information - clinic purposes

3.1 **Your clinic will hold identifying information about you in relation to your or your partner's treatment, your storage or donation. Do you consent to this identifying information being disclosed (to the extent permitted by the Act) to the following groups of people:**

- Your GP
- Other healthcare professionals outside your clinic in order to provide the best possible medical care to yourself or your partner named in section 2
- Auditors or administrative staff outside of the clinic to enable them to perform functions designated to them in connection with the clinic's licensable activities?

Yes, all of the above

No, only some of the above ► Specify below who your information may be disclosed to:

My GP

Other healthcare professionals outside your clinic in order to provide the best possible medical care to yourself or your partner named in section 2

Auditors or administrative staff who give essential support to your clinic

No, not to anyone (other than in a medical emergency)

Page declaration

Your signature

Date

For clinic use only

Patient number

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Version 3 (06/04/10)

4 About your identifying information - medical or other research purposes

Please do not fill in this section if you are donating your eggs, sperm or embryos for the treatment of others, or you are a patient using donor eggs, sperm or embryos in your treatment.

Your information

During the course of your or your partner’s treatment, information about yourself (including your health and other issues relevant to your treatment) is collected.

If you are receiving treatment, then information about any child born as a result of this will also be collected. Some of this information is sent to the HFEA and recorded on the HFEA Register.

This information can be of great use to researchers investigating, for example, how treatment can be improved.

Your consent

The law allows for information that identifies you (e.g. your name and date of birth) to be disclosed to researchers, although this may only happen if you give your consent.

Children born as a result of treatment

The HFEA will use any consent you give in this section to inform how, in future, information on the HFEA Register is processed about any child born as a result of your treatment, until they reach the age of 16.

For example, if you consent in this section to your identifying information held on the HFEA Register being disclosed for medical and non-medical research purposes, then the HFEA may also release that of any child born as a result of your treatment.

Equally, if you do not consent in this section to your identifying information being disclosed for research purposes, then the HFEA will not release that of any child born as a result of your treatment.

Notifying your centre

You should notify your centre if you do not wish the consent you give in this section about the use of your own data to inform how data about children is processed. Notification, if necessary, should be given after the child’s birth.

It is your right to change the consent you give here at any time.

Continues on the next page

Page declaration

Your signature

X

Date

DD MM YY

For clinic use only

Patient number

4 Medical or other research purposes *continued*

4.1. Do you consent to identifying information from the HFEA Register being disclosed to medical and non-medical researchers?

This information can be about your or your partner's treatment, including any storage of your eggs, sperm or embryos and donation of your eggs, sperm or embryos for research (if applicable).

This could involve a member of staff from the centre where you received treatment contacting you to inform you of a particular research study for which you may be a suitable participant.

- No ►► *Go straight to section 5*
- Yes ► *Go straight to section 5*
- Yes, but only for some types of research ► *Go to section 4.2.*

4.2. Please specify the types of research that you wish to provide consent for.

Non-contact research

I consent to information about my treatment being disclosed for the purpose of research that does not involve my direct participation. This might include studies that involve linking HFEA register information to other health databases, in order to carry out statistical analyses.

- No
- Yes

Contact research

I consent to information about my treatment being disclosed for the purpose of research that would involve my direct participation.

I understand that this could involve a member of staff from the centre where I received treatment contacting me to inform me of a particular research study for which I may be a suitable participant. I also understand that any possible participation in a study is entirely optional and that the consent I give on this form is only to being contacted with an invitation to participate.

- No
- Yes

Page declaration

Your signature

Date

For clinic use only

Patient number

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 sections 3 and 4 of this form, and
 - the implications of giving my consent, and the consequences of withdrawing this consent, have been fully explained to me.
- I understand that I can make changes to or withdraw my consent at any time but that it will not be possible to withdraw my information from research where my information has already been included within analysis.
- I declare that, in relation to section 4, I have read and understood the information provided and have had the opportunity to ask questions and seek further clarification. I understand that the choices I have made about participating in research will not affect the care and treatment I receive. I have given / withheld my permission freely.
- I understand that information on this form may be processed and shared for the purposes of and in connection with the conduct of licensable activities under the Human Fertilisation and Embryology Act 1990 (as amended) in accordance with the provisions of that Act.

Your signature

Date

If signing to witness consent

If the person consenting is unable to sign for him or herself because of physical illness, injury or disability, someone else representing the person can sign the form at his or her direction as a record of his or her consent. There must also be a witness confirming that the person consenting is present when the representative signs the form.

Representative's signature

I declare that the person named in section 1 of this form is present at the time of signing this form and I am signing in accordance with his or her direction as a record of his or her consent.

Representative's name

Representative's signature

Relationship to the person consenting

Date

Witness's name

Witness's signature

Date