# Your consent to disclosing identifying information (part one – general purposes)

## About this form

### Who should fill in this form?

This form is produced by the Human Fertilisation and Embryology Authority (HFEA), the UK's independent regulator of fertility treatment and human embryo research. For more information about us, visit **www.hfea.gov.uk**.

### Who should fill in this form?

Fill in this form if:

- you or your partner are receiving fertility 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 a donor, any consent given in this form will not affect your legal rights and responsibilities. Your information will only be disclosed to the parties you agree to on this form.

### What do I need to know 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
- what identifying information may be disclosed and how it would be shared, and
- how you can make changes to, or withdraw, your consent.

If you are unsure of anything in relation this, please ask your clinic.

If you are being treated together with a partner, both you and your partner must fill in a copy of this form. Before completing it, please discuss with your partner what information you agree to be disclosed as there may be implications if you do not consent to the same level of disclosure.

If you are unable to complete this form because of physical illness, injury or disability, you may direct someone else to complete and sign it for you.

### Why do I have to fill in this form?

Your clinic holds identifying information about you such as your name, address and date of birth as well as information about your treatment or care. By law, your clinic must submit some of this information to the HFEA to be stored on a secure fertility treatment database called the HFEA Register.

Sometimes your clinic may want to share some of this identifying information with other parties. For example:

- to discuss your medical history with your GP to plan the most appropriate treatment
- to discuss your treatment with another healthcare professional outside your clinic (eg, gynaecologists or oncologists at another hospital) in order to give you the best possible medical care
- to share information for clerical or financial reasons (eg, with administrative staff or auditors reviewing your clinic's finances).

Your clinic is not allowed to share identifying information with these parties unless you provide your written consent for this (apart from in a medical emergency). This form allows you to provide your consent to sharing your information for any or all of the reasons outlined above.

**When filling in this form, make sure you sign the declaration on every page to confirm that you have read the page and fully agree with the consent and information given. When you have completed this form you may request a copy of it from your clinic.**

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**For clinic use only (optional)**

| **HFEA centre reference** | **Patient number** assigned by clinic | **Other relevant forms** |
|---|---|---|
| | | |

## 1 About you

1.1 **Your first name(s)**

*Place clinic sticker here*

1.2 **Your surname**

1.3 **Your date of birth**

D D M M Y Y

1.4 **Your NHS/CHI/HCN/passport number** (please circle)

## 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**

D D M M Y Y

2.4 **Your partner's NHS/CHI/HCN/passport number** (please circle)

## 3 Disclosing your identifying information to support your care/treatment

**Do you consent to identifying information about you being disclosed to the following groups of people? Tick the options you consent to.**

☐ **Your GP.** Your clinic may want to discuss your medical history with your GP to plan the most appropriate treatment.

☐ **Other healthcare professionals**. Your clinic may want to discuss your treatment with another healthcare professional (eg, gynaecologists or oncologists at another hospital) to give you the best possible care.

☐ **Auditors or administrative staff outside of your clinic**. Your clinic may want to share information for clerical or financial reasons (eg, with administrative staff or auditors reviewing the clinic's finances).

☐ **Not to anyone** (other than in a medical emergency).

## Page declaration

**Your signature**

✗

**Date**

D D M M Y Y

**For clinic use only (optional)** Patient number

## 4 Declaration

**Please sign and date the declaration**

### Your declaration

- I declare that I am the person named in section one of this form.
- I declare that:
  - before I completed this form, I was given information about the different options set out in section three 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.
- 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**

D D M M Y Y

**If signing to witness consent**

If you have completed this form at the direction of the person consenting (because they are unable to sign for themselves due to physical illness, injury or disability), you must sign and date the declaration below. There must also be a witness confirming that the person consenting is present when you sign the form.

### Representative's signature

I declare that the person named in section one of this form is present at the time of signing this form and I am signing in accordance with their direction.

**Representative's name**

**Representative's signature**

✗

**Relationship to the person consenting**

**Date**

D D M M Y Y

**Witness's name**

**Witness's signature**

✗

**Date**

D D M M Y Y