

**THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES**

**CONSENT TO THE TRANSFER-IN AND STORAGE OF CRYOPRESERVED MATERIALS  
("Transfer In Consent")**

Female Name: \_\_\_\_\_ Female ID# \_\_\_\_\_

Partner Name: \_\_\_\_\_ Partner ID# \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(We) (I) request transfer of (our) (my):  
(Please check each box that applies)

**Frozen embryos**  
(Requires names and signatures of both members of the couple)

**Frozen partner sperm, epididymal and/or testicular tissue**  
(Requires male name and signature only)

**Frozen donor sperm**  
(Requires female recipient name and signature only)

to the possession and control of the Center for Advanced Reproductive Services from the following designated facility or agent:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact Person Phone Number \_\_\_\_\_

We (I) acknowledge that this transfer consent requires the signature of both members of the couple who signed the original embryo cryopreservation consent for embryo transfer, of the male partner only for his sperm, epididymal and/or testicular tissue transfer and of the couple or single female patient for donor sperm. We (I) agree that if we (I) inherited these cryopreserved materials for our (my) own use or obtained the cryopreserved materials for use from a known donor, copies of these agreements and/or consents must be provided along with this consent. In that case, only the signature of the individual(s) involved in that agreement is (are) required.

The Center for Advanced Reproductive Services, PC (The Center), and, as appropriate, its employees, contractors, consultants and authorized agents, agrees to provide its best efforts to receive the cryopreserved material in a container provided by the above named originating physician, program or facility. This receipt will be performed consistent with written directions provided by that originating physician, program or facility. The Center for Advanced Reproductive Services shall *not* be responsible for the safety, physical integrity or identity of the cryopreserved material before it was placed and transported in the container by the patient, physician, program, facility, or any designated agent.

**I (we) am (are) aware that the transporting of cryopreserved material involves certain risks to that material, and if any of this material thaws during transport, it may be damaged or destroyed.**

I (we) agree to accept any and all costs and risks involved in the transporting of the cryopreserved material. I (we) hereby release the Center for Advanced Reproductive Services, its employees, contractors, consultants and authorized agents from any and all responsibility for the safety and integrity of the cryopreserved material, prior to the possession and control of the Center for Advanced Reproductive Services. I (we) acknowledge that the Center for Advanced Reproductive Services makes no guarantees as to the security or method of the packing or transfer method, to the safe thawing of the cryopreserved material, conception rates or to a successful pregnancy. Since the Center for Advanced Reproductive Services did not process this material initially, it cannot be held responsible for errors that may have occurred in sample identification or handling prior to arrival at the Center for Advanced Reproductive Services. I (we) have carefully read this agreement and fully understand its contents. I (we) am (are) aware that this form is a release of liability, and I (we) sign it of my (our) own free will.

Furthermore, we (I) consent to The Center storing our (my) cryopreserved materials for our (my) future use.

Our (my) cryopreserved materials will only be used for our (my) own medical treatments or that of my partner. At no time will the specimens be sold or used by any other individual. Our (my) cryopreserved materials will be available for our (my) use only if our (my) account is paid in full.

We (I) understand that the storage processes involve the use of mechanical and/or electrical equipment. The Center will take reasonable measures to maintain and monitor this equipment. However, despite their best efforts, equipment failure may result in the damage or loss of one or more vials or straws of cryopreserved materials. We (I) understand and agree that The Center shall be responsible only for acts of negligence on its part and the part of its employees, contractors, consultants and authorized agents.

We (I) understand and agree that I will be billed for storage on a quarterly basis and it will continue prospectively every quarter thereafter. Failure to pay storage fees in a timely manner will result in appropriate collection actions.

We (I) understand it is our (my) obligation to notify The Center for Advanced Reproductive Services, PC (The Center), of any change of address, and that if we (I) do not do so, The Center for Advanced Reproductive Services, PC (The Center), is not liable for its inability to contact or bill us (me), or for any destruction of specimens considered abandoned.

We (I) understand that we (I) may decide, at any time, to terminate this agreement and have the specimens destroyed (after signing a disposal consent) or to transfer them to another fertility center or long term storage facility (after signing a consent to transfer cryopreserved materials out), and that the costs and responsibilities are ours (mine). If we (I) choose to destroy our (my) specimens all storage fees will continue to accrue until The Center receives a properly executed Disposal Consent.

Upon our (my) death we (I) intend that these cryopreserved materials will (choose one):

Be destroyed **OR**

Be transferred to my designee \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**(Write in designee name, address and phone number)**

Our (my) designee may authorize use of the cryopreserved materials for their own further attempts to conceive, but may not donate it to anyone else.

We (I) release The Center, its employees, contractors, consultants and authorized agents, from responsibility for the outcome of the freezing and thawing process, including the release of responsibility for occurrence of pregnancy, outcome of pregnancy, including birth defects, and transmission of any infectious disease or genetic abnormality through use of these cryopreserved materials.

I (we) also authorize the release of any of the Center's, Laboratory or Medical Records necessary to permit this transfer.

Furthermore, our (my) signature documents that we (I) have had the opportunity to ask questions and have had these questions answered to our (my) satisfaction.

We (I) acknowledge that this transfer consent requires the signature of both members of the couple who signed the original embryo cryopreservation consent for embryo transfer, of the male partner only for his sperm, epididymal and/or testicular tissue transfer and of the couple or single female patient for donor sperm. We (I) agree that if we (I) inherited these cryopreserved materials for our (my) own use or obtained the cryopreserved materials for use from a known donor, copies of these agreements and/or consents must be provided along with this consent. In that case, only the signature of the individual(s) involved in that agreement is (are) required.

**NOTE: If more than one signature is required, ALL signatures must be notarized. If all partners cannot**

**appear before the notary at the same time, then the form can be duplicated and each partner can sign separately.**

**Please refer to Page 1 for required signatures.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Male Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Female Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Partner Signature \*\*\* **If no partner, write N/A**

**Note: Notarization of ALL signatures is required.**

State of Connecticut )  
County of \_\_\_\_\_ )

On \_\_\_\_\_, before me, \_\_\_\_\_ **(Insert name of**

**Notary)**, personally appeared \_\_\_\_\_ **(List**

**only the names of individuals who actually appeared for this signature)**, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature \_\_\_\_\_ (Seal)

**THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES MUST RECEIVE THIS CONSENT FORM PRIOR TO THE DISPOSAL OF THE MATERIALS. THIS FORM MAY BE MAILED TO:**

Andrology Laboratory  
The Center for Advanced Reproductive Services  
Dowling South Building  
263 Farmington Avenue  
Farmington, CT 06030-6226  
Tel: 860-679-3460

**Physician Signature:** *(for lab use only)*

This consent has been discussed with the patient and her partner, if any.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Physician Signature