

THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES

**CONSENT TO THE TRANSFER-OUT OF CRYOPRESERVED MATERIALS
("Transfer Out Consent")**

Female Name: _____ Female ID# _____

Partner Name: _____ Partner ID# _____

Address: _____

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

out of the Center for Advanced Reproductive Services to the following designated facility or agent:

Contact Person Phone Number _____

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 pack the cryopreserved material in a container provided by the above-named recipient physician, program or facility. Packing will be performed consistent with written directions provided by that physician, program or facility. The Center shall not be responsible for the safety and physical integrity of the cryopreserved material once the container is in the possession of 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 any 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, once it no longer is in 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, or to a successful pregnancy. 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.

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

We (I) acknowledge 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 sperm, epididymal and/or testicular tissue transfer and of the female patient only 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