

CENTER FOR ADVANCED REPRODUCTIVE SERVICES

CONSENT TO DONATE EMBRYOS

Female Name: _____ Female ID# _____

Partner Name: _____ Partner ID# _____

Address: _____

We (I), the undersigned, request, authorize and consent to the donation of our (my) cryopreserved (frozen) embryos by The Center for Advanced Reproductive Services, PC (The Center), and as appropriate, its employees, contractors, consultants and authorized agents, for use by an infertile couple or woman.

We (I) understand that donation is only one of several options we (I) have for the final disposition of our (my) remaining cryopreserved embryos. We (I) may:

1. Use these embryos ourselves (myself) in an effort to have a child.
2. Request that the embryos be discarded according to the American Society for Reproductive Medicine Ethical Guidelines.
3. Have the embryos transferred to another facility for long term storage, for our (my) own use, or so that we (I) may donate the embryos for research.

By our (my) signatures below, we (I) exercise our (my) right to donate the remaining embryos to another infertile couple or woman. We (I) understand and consent that embryos cryopreserved after May 25, 2005 may not be donated **anonymously** unless federally mandated infectious disease testing and related requirements were completed on both the egg and sperm source within 7 days of the egg retrieval. We (I) understand we will not be paid for this donation.

We (I) understand, agree and consent that the selection of the recipient will be determined at the sole discretion of The Center for Advanced Reproductive Services, PC (The Center), and, as appropriate, its employees, contractors, consultants and authorized agents, unless we (I) have listed a specific designated recipient couple or woman.

Please check the appropriate choice and initial:

- The Center may determine the recipient(s) of these embryos.

Female Initials: _____

Partner Initials: _____

- We (I) designate the couple (woman) listed below as the recipient(s) of these embryos.

Designee _____

Female Initials: _____

Partner Initials: _____

We (I) understand that there currently are no statutes in the state of Connecticut concerning embryo donation. By our (my) signatures below, we (I) are giving up all rights to use or make decisions about our (my) embryos. Should the utilization of our (my) cryopreserved embryos by another couple result in the birth of a child, by our (my) signature(s) below, we (I) are (am) giving up all rights and claims to such a child. We (I) acknowledge that the Center will not inform us (me) if our (my) donation results in the birth of a child.

Unless we have designated our recipient(s), we pledge that we will never seek the identities of the recipients, except as allowed below or if a court orders otherwise. We (I) also understand that the Center will protect our (my) identity and will not reveal it to the recipient(s) except as allowed below or if a court orders otherwise.

However, we (I) understand that if a child born from this donation has a medical or psychological need that might be met by us (me), then the recipient(s) may contact the Center and ask that their request be relayed to us (me). Such requests may be for a medical need such as a bone marrow transplant, or, **once any child or children born from this donation are legal adults**, a request may be made by the child or children for our identities.

We (I) understand and agree that, if we have designated a recipient for these embryos, that aspects of our (my) medical care and conditions and that of the recipient may be revealed and/or discerned as part of the treatment process.

We (I) consent to any blood tests, infectious disease or genetic testing and any other tests, interviews or screening required to permit donation of these embryos as mandated by federal law. We (I) understand and consent that embryos cryopreserved after May 25, 2005 may not be donated *anonymously* unless federally mandated infectious disease testing and related requirements were completed on both the egg and sperm source within 7 days of the egg retrieval. We (I) understand that the cost of this testing may be born by the intended recipient(s). We (I) further acknowledge and consent that medical, psychological, genetic/infectious disease, technical or other considerations may contraindicate or preclude the donation of these embryos to a recipient despite our (my) request. We (I) agree that the disposition of these embryos will ultimately rely on the best medical judgement of The Center for Advanced Reproductive Services, PC (The Center), and as appropriate, its employees, contractors, consultants and authorized agents, at the time of the potential donation. We (I) agree to notify The Center of any medical condition or disease, particularly genetic diseases, that arises in us (me) or our (my) immediate family. We (I) understand and agree that if either of us (I) is adopted that the embryos cannot be donated for use in producing a pregnancy.

We (I) understand and agree that if these embryos cannot be donated for use by a recipient, for any of the reasons described above, we have two options (Please check and initial the appropriate choice):

- Discard the embryos according the American Society of Reproductive Medicine Ethical Guidelines.

Female Initials: _____

Partner Initials: _____

- Donate the embryos for use in medical research.

Female Initials: _____

Partner Initials: _____

It is our (my) understanding that all rights and responsibilities for the care of any child resulting from the donation of our (my) excess embryos will be the responsibility of the recipient couple (woman). This includes any financial burdens associated with the care and upbringing of such a child.

We (I) have had the opportunity to review this option and ask questions of our (my) physician concerning the alternative options to Embryo Donation.

The nature of Embryo Donation has been explained to us (me). We (I), understand the explanation that has been given to us (me). We (I) have had the opportunity to ask any questions we (I) might have and those questions have been answered to our (my) satisfaction. Any further questions may be addressed to The Center staff or IVF Program Director, Dr. John Nulsen at (860) 679-4580. We (I) acknowledge that Embryo Donation is being performed at our (my) request and with our (my) consent.

We (I) acknowledge this consent requires the signature of both members of the couple who signed the original embryo cryopreservation consent. We (I) agree that if an individual or couple has inherited these cryopreserved materials for their (his/her) 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 TWO signatures are required, BOTH signatures must be notarized. If both partners cannot appear before the notary at the same time, then the form can be duplicated and each partner can sign separately.

_____/_____/_____
Date Female Signature

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

Note: Notarization of BOTH 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 TRANSFER OF THE MATERIALS. THIS FORM MAY BE MAILED TO:

John Nulsen, MD, Program Director
The Center for Advanced Reproductive Medicine
Dowling South Building
263 Farmington Avenue
Farmington, CT 06030
Tel: 860-679-4580

Physician Signature:

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

_____/_____/_____
Date Physician Signature