

**OHSU FERTILITY CONSULTANTS
OREGON HEALTH AND SCIENCE UNIVERSITY**

Affix Patient
Identifying Label
Here

**CONSENT FOR
HUMAN EMBRYO
CRYOPRESERVATION**

Affix Male Partner's
Identifying Label
Here

I, _____ and _____, agree to
female partner male partner (if applicable)

have selected embryos from my/our IVF cycle cryopreserved by the OHSU Fertility Consultants. I/we understand that there is neither any guarantee for the successful freezing of the embryos nor their subsequent use for my infertility treatment. I/we acknowledge that embryo cryopreservation may or may not be recommended in our IVF cycle. *I/we understand that if cryopreservation is recommended then not all of my/our embryos may be selected for cryopreservation, but that this decision will be discussed with us at the time of our fresh embryo transfer.*

I/we understand that the pregnancy rate with the use of cryopreserved embryos may be expected to be lower than that experienced with fresh embryos used during an IVF cycle. In addition, I/we acknowledge that the process of cryopreservation and subsequent thawing is technically difficult and some of the embryos could be damaged during the procedure. I/we understand that with any technical process that requires mechanical support, unforeseen failure of equipment can occur. In addition, we understand that other situations could occur that could cause mechanical failure and affect the viability of cryopreserved embryos (e.g. natural disasters including floods, earthquakes, and etc.) I/we understand that back-up systems will be utilized to decrease the impact of any mechanical failure on cryopreservation and storage. I/we agree that neither the OHSU Fertility Consultants nor any of their employees shall be held liable for the loss, injury or destruction of my/our embryos caused by situations that are beyond the control of OHSU Fertility Consultants.

I/we acknowledge that annual storage fees will apply as long as we have frozen embryos stored at OHSU Fertility Consultants. While the first year of storage is included in the cryopreservation fee, I/we understand that annual payment for subsequent years will be necessary to continue ongoing storage with OHSU Fertility Consultants.

I/we acknowledge that control over the status of my cryopreserved embryos belongs solely to me/us for as long as we comply with all of the conditions specified throughout this consent form. The options for these embryos are as listed below:

1. Use the frozen embryos to attempt to establish a pregnancy in the Female Partner.
2. Direct that the embryos be discarded in a medically appropriate manner.
3. Elect to transfer control of the embryos to the University Fertility Consultants for use in approved research protocols (but not for donation to another infertile patient).
4. Request that the embryos be released from the custody of the University Fertility Consultants and be shipped to another ART facility.
5. Elect to donate the embryos to another infertile person/couple, either anonymously or via directed donation. I/we understand that we would have to undergo further testing for sexually transmitted diseases and qualify for the embryo donation program in order to participate.

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I/we understand that the options for the status of the embryos listed above must be made by mutual consent of both partners (if applicable) who created the embryos. If one of the partners is deceased (as established by a certified copy of a death certificate), we understand that the remaining partner obtains sole custodial control over the status of the embryos. I/we understand that one of the partners may obtain sole custodial control over the embryos by court order or other legal instrument. We understand that in the event of separation or divorce, both parties who created the embryos must mutually agree upon future status decisions unless court papers have given full control to one partner. I/we acknowledge that if mutual consent between partners (if applicable) cannot be established, the embryos will remain in storage at OHSU Fertility Consultants provided that all applicable storage fees are paid on an annual basis.

I/we acknowledge that while we have frozen embryos in storage, the OHSU Fertility Consultants will, to the best of its ability attempt to contact us on an annual basis to determine my/our wishes for the status of these embryos. I/we further acknowledge our responsibility to respond to the annual renewal letters within 30 days of receipt or the control and direction of the status of these embryos will be placed with the OHSU Fertility Consultants. I/we understand that if the OSHU Fertility Consultants is unable to locate or contact us for annual renewal then control over the status of these embryos will be placed with the OHSU Fertility Consultants within 30 days of their final attempt at contact.

I/we agree to relinquish all control over the status of our cryopreserved embryos to the OHSU Fertility Consultants under the following circumstances:

1. In the event of the death of both partners and no legal arrangement has been made by me/us for the ongoing status of the embryos under such circumstances, or
2. At any time by my/our election, or
3. If I/we have not maintained our annual renewal for embryo storage. In this event, we understand that the University Fertility Consultants will, to the best of its ability, attempt to contact us before it exercises its control over the frozen embryos, or
4. If I/we have not remained in contact with the OHSU Fertility Consultants for a period exceeding five years.

I/we acknowledge that I/we have read this consent form and discussed the cryopreservation of embryos with members of the OHSU Fertility Consultants and authorize the cryopreservation of selected embryos from my/our IVF cycle. I/we acknowledge that embryo cryopreservation may or may not be recommended in our IVF cycle. *I/we understand that if cryopreservation is recommended in this IVF cycle, not all of my/our embryos may be selected for cryopreservation.* I/we have had the benefits and risks of this procedure explained to us by and had our questions answered to our full satisfaction. I/we hereby agree to all of the terms and conditions in this consent form.

Signature, female partner	Date	Signature, male partner	Date
Signature, medical staff witness	Date	Signature, medical staff witness	Date

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Signatures must be verified by a Notary Public (see below) if this consent is not signed in the presence of a medical staff member at the OHSU Fertility Consultants:

I/we acknowledge that I/we have read this consent form and discussed the cryopreservation of embryos with members of the OHSU Fertility Consultants and authorize the cryopreservation of selected embryos from my/our IVF cycle. I/we acknowledge that embryo cryopreservation may or may not be recommended in our IVF cycle. *I/we understand that if cryopreservation is recommended in this IVF cycle, not all of my/our embryos may be selected for cryopreservation.* I/we have had the benefits and risks of this procedure explained to us by and had our questions answered to our full satisfaction. I/we hereby agree to all of the terms and conditions in this consent form.

Signature, female partner Date Signature, male partner Date

Witness by Notary Public

State of _____, County of _____
I certify that I know or have satisfactory evidence that

_____ and _____
are the persons who appeared before me, and said persons acknowledged that they signed this instrument and acknowledged it to be their free and voluntary act for the uses and purposes mentioned in the instrument.

Date _____

(Signature of Notary Public)

(Title)

My appointment expires: _____ Residing in: _____

Patient Contact Information

Address

City, State ZIP

Phone

Alternate Phone

Emergency Contact Person (e.g. Mother)

Name

Address

City, State Zip

Phone