UNIVERSITY of ROCHESTER MEDICAL CENTER

Strong Fertility Center
500 Red Creek Dr., Suite 220, Rochester, NY 14623
Phone: 585.487.3378 Fax: 585.334.8998

Patient Name: Patient DOB: MRN:

CONSENT TO TRANSFER CRYOPRESERVED GAMETES OR EMBRYOS

I/We, _____ hereby confirm the request to have the frozen reproductive specimens designated below transferred from the custody of Strong Fertility Center (hereinafter referred to as "SFC") to another physician, clinic, laboratory, or healthcare facility (hereinafter referred to as "facility") of our choosing as indicated below.

Please check one: ☐ Oocytes (eggs) ☐ Embryos ☐ Sperm

Facility Name: _____

Facility Contact Name: _____

Facility Contact Phone Number: _____

I/We understand that:

1. The gametes or embryo(s) were frozen using the currently available techniques.
2. The above designated facility will document to SFC their willingness to receive the gametes or embryo(s) prior to shipment.
3. The gametes or embryo(s) will be shipped in a liquid nitrogen dry shipper via a commercial airline carrier / courier or other pre-arranged transport methods.
4. Instructions concerning handling and thawing of the gametes or embryo(s) will be provided by SFC to the designated facility.
5. SFC will take no responsibility to investigate the expertise, credentials, or certification of the institution or the personnel designated to receive the gametes or embryo(s).

The risks associated with this transfer have been explained, and I/we fully understand the risks involved in the transport and storage of gametes and embryos, including the possible inadvertent thawing and destruction of the gametes or embryos while in the care of a third party. I/We also understand that there is no guarantee that the gametes or embryos will survive the thawing process or create a pregnancy at the outside facility. With knowledge of these risks, I/we accept responsibility for the decision to transfer the frozen gametes or embryo(s) to the designated facility.

I/We hereby release SFC, its agents, officers, and personnel from all liability concerning the aforementioned gametes or embryo(s). I/We acknowledge that I/we have read and fully understand all information in this consent and have been given the opportunity to request clarification of any aspects not fully understood. By signing below, I/we consent and understand the risks involved when transferring the frozen gametes or embryo(s) to another facility.

PATIENT: Signature: _____ Date: _____

PARTNER: Signature: _____ Date: _____

WITNESS Name: _____ Signature: _____ Date: _____
Physician/Physician Designee/Notary