Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT TO RECEIVE DONATED OOCYTES OR EMBRYOS

I/We ____ (Intended Parent) and, if applicable, ________________________________, (Intended Parent's partner), are over eighteen (18) years of age.

I/We are participating voluntarily in the Lucile Salter Packard Children's Hospital at Stanford ("LPCH") Fertility and Reproductive Health program because I/we have elected to have certain donated oocytes or embryos transferred to the uterus of the Intended Parent or a gestational carrier in the hope that a pregnancy will result. I/We understand that LPCH will receive cryopreserved, or "frozen," embryos from individuals (the "Donors") selected by me/us.

I/We further understand that I/we may elect to receive donated oocytes or embryos from three potential embryo sources as described below, and I/we have indicated the type of donor selected by me/us below ***(initial the proper donor source below):***

Recipient	Partner	
_________	_________	Donors known to me/us and as permitted by LPCH;
_________	_________	Anonymous Donors whose oocytes or embryos are under the custody and control of LPCH as permitted by LPCH; or
_________	_________	Adoption/Donation agency ("Agency").

I/we understand that to the extent I/we have elected to receive oocytes or embryos donated by known or anonymous Donors as identified above, LPCH has, or shall obtain prior to beginning any embryo transfer treatment for me, a signed "Consent to Donate Oocytes or Embryos to an Individual or Couple" (the "Donor Consent") in substantially the form attached hereto as Exhibit A.

I/we also understand that to the extent I/we have elected to receive embryos from an Agency, LPCH has or shall obtain an "Agency Attestation to Donor Consent and Wishes for Disposition of Excess Embryos" ("Agency Attestation"). I/we further understand it is the policy of LPCH to accept Agency embryos only to the extent such embryos are free from future use restrictions such that the Intended Parents may direct LPCH to utilize any excess embryos.

[1] Note that embryo donation from known Donors may include a directed donation intended specifically for you, or may include a donation from a prior recipient of donated embryos who has now elected to donate excess embryos to you, in accordance with the Intended Parent's and, to the extent applicable Intended Parent's Partner's, wishes. To the extent I/we have elected to receive embryos from an Agency, I/We understand that (i) LPCH was not involved in the creation, cryopreservation, initial storage or selection of the donated embryos and that (ii) gamete retrieval, embryo creation, cryopreservation and initial storage were performed at fertility clinic(s) other than LPCH. I/We understand that LPCH does not and cannot make any representation as to the condition or viability of any Agency donated embryos or the genetic make-up or medical condition of Agency Donors.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT TO RECEIVE DONATED OOCYTES OR EMBRYOS

I/We____(Intended Parent) and, if applicable, _________________________________, (Intended Parent's partner), are over eighteen (18) years of age.

I/We are participating voluntarily in the Lucile Salter Packard Children's Hospital at Stanford ("LPCH") Fertility and Reproductive Health program because I/we have elected to have certain donated oocytes or embryos transferred to the uterus of the Intended Parent or a gestational carrier in the hope that a pregnancy will result. I/We understand that LPCH will receive cryopreserved, or "frozen," embryos from individuals (the "Donors") selected by me/us.

I/We further understand that I/we may elect to receive donated oocytes or embryos from three potential embryo sources as described below, and I/we have indicated the type of donor selected by me/us below ***(initial the proper donor source below):***

Recipient	Partner	
_________	_________	Donors known to me/us and as permitted by LPCH;
_________	_________	Anonymous Donors whose oocytes or embryos are under the custody and control of LPCH as permitted by LPCH; or
_________	_________	Adoption/Donation agency ("Agency").

I/we understand that to the extent I/we have elected to receive oocytes or embryos donated by known or anonymous Donors as identified above, LPCH has, or shall obtain prior to beginning any embryo transfer treatment for me, a signed "Consent to Donate Oocytes or Embryos to an Individual or Couple" (the "Donor Consent") in substantially the form attached hereto as Exhibit A.

I/we also understand that to the extent I/we have elected to receive embryos from an Agency, LPCH has or shall obtain an "Agency Attestation to Donor Consent and Wishes for Disposition of Excess Embryos" ("Agency Attestation"). I/we further understand it is the policy of LPCH to accept Agency embryos only to the extent such embryos are free from future use restrictions such that the Intended Parents may direct LPCH to utilize any excess embryos.

[1]Note that embryo donation from known Donors may include a directed donation intended specifically for you, or may include a donation from a prior recipient of donated embryos who has now elected to donate excess embryos to you, in accordance with the Intended Parent's and, to the extent applicable Intended Parent's Partner's, wishes. To the extent I/we have elected to receive embryos from an Agency, I/We understand that (i) LPCH was not involved in the creation, cryopreservation, initial storage or selection of the donated embryos and that (ii) gamete retrieval, embryo creation, cryopreservation and initial storage were performed at fertility clinic(s) other than LPCH. I/We understand that LPCH does not and cannot make any representation as to the condition or viability of any Agency donated embryos or the genetic make-up or medical condition of Agency Donors.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT TO RECEIVE DONATED OOCYTES OR EMBRYOS

I/We ____(Intended Parent) and, if applicable, ________________________________, (Intended Parent's partner), are over eighteen (18) years of age.

I/We are participating voluntarily in the Lucile Salter Packard Children's Hospital at Stanford ("LPCH") Fertility and Reproductive Health program because I/we have elected to have certain donated oocytes or embryos transferred to the uterus of the Intended Parent or a gestational carrier in the hope that a pregnancy will result. I/We understand that LPCH will receive cryopreserved, or "frozen," embryos from individuals (the "Donors") selected by me/us.

I/We further understand that I/we may elect to receive donated oocytes or embryos from three potential embryo sources as described below, and I/we have indicated the type of donor selected by me/us below ***(initial the proper donor source below):***

Recipient	Partner	
_________	_________	Donors known to me/us and as permitted by LPCH;
_________	_________	Anonymous Donors whose oocytes or embryos are under the custody and control of LPCH as permitted by LPCH; or
_________	_________	Adoption/Donation agency ("Agency").

I/we understand that to the extent I/we have elected to receive oocytes or embryos donated by known or anonymous Donors as identified above, LPCH has, or shall obtain prior to beginning any embryo transfer treatment for me, a signed "Consent to Donate Oocytes or Embryos to an Individual or Couple" (the "Donor Consent") in substantially the form attached hereto as Exhibit A.

I/we also understand that to the extent I/we have elected to receive embryos from an Agency, LPCH has or shall obtain an "Agency Attestation to Donor Consent and Wishes for Disposition of Excess Embryos" ("Agency Attestation"). I/we further understand it is the policy of LPCH to accept Agency embryos only to the extent such embryos are free from future use restrictions such that the Intended Parents may direct LPCH to utilize any excess embryos.

[1]Note that embryo donation from known Donors may include a directed donation intended specifically for you, or may include a donation from a prior recipient of donated embryos who has now elected to donate excess embryos to you, in accordance with the Intended Parent's and, to the extent applicable Intended Parent's Partner's, wishes. To the extent I/we have elected to receive embryos from an Agency, I/We understand that (i) LPCH was not involved in the creation, cryopreservation, initial storage or selection of the donated embryos and that (ii) gamete retrieval, embryo creation, cryopreservation and initial storage were performed at fertility clinic(s) other than LPCH. I/We understand that LPCH does not and cannot make any representation as to the condition or viability of any Agency donated embryos or the genetic make-up or medical condition of Agency Donors.

I. Issues Related to the Embryos and Embryo Donors

A. Ownership Rights.

I/We understand that the Donors have relinquished and surrendered any legal rights or claims to any donated embryo that is transferred and to any child(ren) that may result from the Recipient's, or gestational carrier's, pregnancy. I/We understand that the Donors may have the ability to withdraw from the embryo donation program prior to transfer of donated embryos to the uterus of the Intended Parent or a gestational carrier.

B. Acceptance of Parentage.

I/We understand that the child(ren) conceived by embryo donation will not have any of my/our genetic material but will have the genetic material of the Donors. Unknown or undesirable genetic characteristics of the Donors might be expressed in a child resulting from donated embryos. I/We also understand that any child resulting from a donated embryo has the usual risks of developmental, psychological and physical disabilities and/or illness like any child conceived other than through embryo donation. With full knowledge of the above, I/we hereby state my/our express agreement and intent that I/we shall conclusively be presumed to be the sole legal parent(s) of any fetus(es) and/or child(ren) resulting from transfer to the Intended Parent's or gestational carrier's uterus of a donated embryo, as authorized by this consent form (the "Consent"). As the legal parent(s), I/we hereby agree to assume all parental, custodial and testamentary rights and obligations with respect to such fetus(es) and/or child(ren).

C. Screening and Testing of Donors.

I/we understand that it is possible to acquire an infectious disease, including HIV (the virus that causes AIDS), through the embryo donation process. I/We also understand that, except in limited circumstances, federal and state law require that donors of sperm, ova and embryos are screened and tested for certain disease risk factors and disease agents to determine whether the sperm, ova or embryos are eligible for transfer. I/We understand that, to the extent that the embryos were created from the female Donor's ova and from sperm of a sexually intimate partner of the female Donor for reproductive use by the Donor(s) herself (themselves), the ova and sperm were exempt from federal screening and testing requirements and may not have been screened or tested for infectious diseases at the time the embryos were created. I/We understand that LPCH, or another clinic on behalf of Agency or Donors, subsequently screened and tested for infectious diseases those Donors who were not screened or tested at the point of embryo creation, and found them to meet the requirements under federal and state law for donor eligibility. To the extent the donated embryos were not screened at the time the embryos were created, I/We have been informed of the risks inherent in the transfer of embryos that were created from the ova and sperm of other persons and that were not screened or tested for infectious diseases at the time they were created. To the extent applicable, I/We have consented to these risks in a separate consent attached to this Consent entitled "Consent to Use Donated Reproductive Cell or Tissue from an Embryo Donor Determined to Be Exempt."

I. Issues Related to the Embryos and Embryo Donors

A. Ownership Rights.

I/We understand that the Donors have relinquished and surrendered any legal rights or claims to any donated embryo that is transferred and to any child(ren) that may result from the Recipient's, or gestational carrier's, pregnancy. I/We understand that the Donors may have the ability to withdraw from the embryo donation program prior to transfer of donated embryos to the uterus of the Intended Parent or a gestational carrier.

B. Acceptance of Parentage.

I/We understand that the child(ren) conceived by embryo donation will not have any of my/our genetic material but will have the genetic material of the Donors. Unknown or undesirable genetic characteristics of the Donors might be expressed in a child resulting from donated embryos. I/We also understand that any child resulting from a donated embryo has the usual risks of developmental, psychological and physical disabilities and/or illness like any child conceived other than through embryo donation. With full knowledge of the above, I/we hereby state my/our express agreement and intent that I/we shall conclusively be presumed to be the sole legal parent(s) of any fetus(es) and/or child(ren) resulting from transfer to the Intended Parent's or gestational carrier's uterus of a donated embryo, as authorized by this consent form (the "Consent"). As the legal parent(s), I/we hereby agree to assume all parental, custodial and testamentary rights and obligations with respect to such fetus(es) and/or child(ren).

C. Screening and Testing of Donors.

I/we understand that it is possible to acquire an infectious disease, including HIV (the virus that causes AIDS), through the embryo donation process. I/We also understand that, except in limited circumstances, federal and state law require that donors of sperm, ova and embryos are screened and tested for certain disease risk factors and disease agents to determine whether the sperm, ova or embryos are eligible for transfer. I/We understand that, to the extent that the embryos were created from the female Donor's ova and from sperm of a sexually intimate partner of the female Donor for reproductive use by the Donor(s) herself (themselves), the ova and sperm were exempt from federal screening and testing requirements and may not have been screened or tested for infectious diseases at the time the embryos were created. I/We understand that LPCH, or another clinic on behalf of Agency or Donors, subsequently screened and tested for infectious diseases those Donors who were not screened or tested at the point of embryo creation, and found them to meet the requirements under federal and state law for donor eligibility. To the extent the donated embryos were not screened at the time the embryos were created, I/We have been informed of the risks inherent in the transfer of embryos that were created from the ova and sperm of other persons and that were not screened or tested for infectious diseases at the time they were created. To the extent applicable, I/We have consented to these risks in a separate consent attached to this Consent entitled "Consent to Use Donated Reproductive Cell or Tissue from an Embryo Donor Determined to Be Exempt."

I. Issues Related to the Embryos and Embryo Donors

A. Ownership Rights.

I/We understand that the Donors have relinquished and surrendered any legal rights or claims to any donated embryo that is transferred and to any child(ren) that may result from the Recipient's, or gestational carrier's, pregnancy. I/We understand that the Donors may have the ability to withdraw from the embryo donation program prior to transfer of donated embryos to the uterus of the Intended Parent or a gestational carrier.

B. Acceptance of Parentage.

I/We understand that the child(ren) conceived by embryo donation will not have any of my/our genetic material but will have the genetic material of the Donors. Unknown or undesirable genetic characteristics of the Donors might be expressed in a child resulting from donated embryos. I/We also understand that any child resulting from a donated embryo has the usual risks of developmental, psychological and physical disabilities and/or illness like any child conceived other than through embryo donation. With full knowledge of the above, I/we hereby state my/our express agreement and intent that I/we shall conclusively be presumed to be the sole legal parent(s) of any fetus(es) and/or child(ren) resulting from transfer to the Intended Parent's or gestational carrier's uterus of a donated embryo, as authorized by this consent form (the "Consent"). As the legal parent(s), I/we hereby agree to assume all parental, custodial and testamentary rights and obligations with respect to such fetus(es) and/or child(ren).

C. Screening and Testing of Donors.

I/we understand that it is possible to acquire an infectious disease, including HIV (the virus that causes AIDS), through the embryo donation process. I/We also understand that, except in limited circumstances, federal and state law require that donors of sperm, ova and embryos are screened and tested for certain disease risk factors and disease agents to determine whether the sperm, ova or embryos are eligible for transfer. I/We understand that, to the extent that the embryos were created from the female Donor's ova and from sperm of a sexually intimate partner of the female Donor for reproductive use by the Donor(s) herself (themselves), the ova and sperm were exempt from federal screening and testing requirements and may not have been screened or tested for infectious diseases at the time the embryos were created. I/We understand that LPCH, or another clinic on behalf of Agency or Donors, subsequently screened and tested for infectious diseases those Donors who were not screened or tested at the point of embryo creation, and found them to meet the requirements under federal and state law for donor eligibility. To the extent the donated embryos were not screened at the time the embryos were created, I/We have been informed of the risks inherent in the transfer of embryos that were created from the ova and sperm of other persons and that were not screened or tested for infectious diseases at the time they were created. To the extent applicable, I/We have consented to these risks in a separate consent attached to this Consent entitled "Consent to Use Donated Reproductive Cell or Tissue from an Embryo Donor Determined to Be Exempt."

D. Transport.

Any Agency or other laboratory in which Agency donated embryos are currently being stored will be responsible for shipping the donated embryos to LPCH. There are inherent risks to shipment, including but not limited to loss, unintentional thawing or other damage. LPCH will not be responsible for any Agency embryos until it accepts receipt and takes custody of the embryos and will no longer be responsible for any embryo once the embryos are no longer in LPCH's possession. LPCH may refuse acceptance of any Agency-donated embryos if it believes them to have been compromised in any way. LPCH has the right to move Agency embryos to another location at any time in the future if necessary based upon the space needs of LPCH. LPCH will also ship Agency embryos to another storage bank or location at my/our request or to Agency, if applicable, in the event of my/our death, incapacity or non-payment of fees, as described below and in the Advanced Written Directive attached to this Consent. I/We understand that I/we must pay the costs of transportation of any embryos for which I/we may request transport or necessitated by non-payment. LPCH is not responsible for the handling of the embryos or any damage the embryos may suffer during this transportation.

E. Storage.

LPCH will store the embryos in a cryopreserved state until the embryos are transferred or are transported to another storage facility. Cryopreservation of the embryos depends on mechanical support systems. Equipment failure or other malfunctions causing damage to or loss of embryos could occur. I/We agree that neither LPCH nor Stanford University shall be liable for any loss, destruction, damage or improper freezing, maintenance, storage, withdrawal, thawing, and/or delivery of embryos, whether caused by or resulting from any malfunction of the equipment, failure of utilities, natural disaster, physical disturbance or otherwise; provided, however, that such loss, destruction, damage or improper handling is not caused by the negligence or willful misconduct of LPCH or Stanford University.

If I/we should [both] die or become permanently incapable of determining the fate of my/our stored frozen embryos or if I/we fail to pay the fees for storage, LPCH will no longer be responsible for storing the embryos, and will handle them in accordance with my/our direction in the Advanced Written Directive attached to this Consent.

LPCH reserves the right to terminate its embryo cryostorage program at any time. In the event of such termination, LPCH will provide at least three (3) months prior notice to allow me/us to identify another facility willing to accept the frozen embryos for storage. In the event that arrangements for transfer of the embryos to another facility are not made during such notice period, and in the absence of other contrary written instructions from me/us, I/we hereby authorize LPCH to transfer any embryos of mine/ours to another facility or to take any other actions with respect to the embryos permitted under applicable law.

D. Transport.

Any Agency or other laboratory in which Agency donated embryos are currently being stored will be responsible for shipping the donated embryos to LPCH. There are inherent risks to shipment, including but not limited to loss, unintentional thawing or other damage. LPCH will not be responsible for any Agency embryos until it accepts receipt and takes custody of the embryos and will no longer be responsible for any embryo once the embryos are no longer in LPCH's possession. LPCH may refuse acceptance of any Agency-donated embryos if it believes them to have been compromised in any way. LPCH has the right to move Agency embryos to another location at any time in the future if necessary based upon the space needs of LPCH. LPCH will also ship Agency embryos to another storage bank or location at my/our request or to Agency, if applicable, in the event of my/our death, incapacity or non-payment of fees, as described below and in the Advanced Written Directive attached to this Consent. I/We understand that I/we must pay the costs of transportation of any embryos for which I/we may request transport or necessitated by non-payment. LPCH is not responsible for the handling of the embryos or any damage the embryos may suffer during this transportation.

E. Storage.

LPCH will store the embryos in a cryopreserved state until the embryos are transferred or are transported to another storage facility. Cryopreservation of the embryos depends on mechanical support systems. Equipment failure or other malfunctions causing damage to or loss of embryos could occur. I/We agree that neither LPCH nor Stanford University shall be liable for any loss, destruction, damage or improper freezing, maintenance, storage, withdrawal, thawing, and/or delivery of embryos, whether caused by or resulting from any malfunction of the equipment, failure of utilities, natural disaster, physical disturbance or otherwise; provided, however, that such loss, destruction, damage or improper handling is not caused by the negligence or willful misconduct of LPCH or Stanford University.

If I/we should [both] die or become permanently incapable of determining the fate of my/our stored frozen embryos or if I/we fail to pay the fees for storage, LPCH will no longer be responsible for storing the embryos, and will handle them in accordance with my/our direction in the Advanced Written Directive attached to this Consent.

LPCH reserves the right to terminate its embryo cryostorage program at any time. In the event of such termination, LPCH will provide at least three (3) months prior notice to allow me/us to identify another facility willing to accept the frozen embryos for storage. In the event that arrangements for transfer of the embryos to another facility are not made during such notice period, and in the absence of other contrary written instructions from me/us, I/we hereby authorize LPCH to transfer any embryos of mine/ours to another facility or to take any other actions with respect to the embryos permitted under applicable law.

D. Transport.

Any Agency or other laboratory in which Agency donated embryos are currently being stored will be responsible for shipping the donated embryos to LPCH. There are inherent risks to shipment, including but not limited to loss, unintentional thawing or other damage. LPCH will not be responsible for any Agency embryos until it accepts receipt and takes custody of the embryos and will no longer be responsible for any embryo once the embryos are no longer in LPCH's possession. LPCH may refuse acceptance of any Agency-donated embryos if it believes them to have been compromised in any way. LPCH has the right to move Agency embryos to another location at any time in the future if necessary based upon the space needs of LPCH. LPCH will also ship Agency embryos to another storage bank or location at my/our request or to Agency, if applicable, in the event of my/our death, incapacity or non-payment of fees, as described below and in the Advanced Written Directive attached to this Consent. I/We understand that I/we must pay the costs of transportation of any embryos for which I/we may request transport or necessitated by non-payment. LPCH is not responsible for the handling of the embryos or any damage the embryos may suffer during this transportation.

E. Storage.

LPCH will store the embryos in a cryopreserved state until the embryos are transferred or are transported to another storage facility. Cryopreservation of the embryos depends on mechanical support systems. Equipment failure or other malfunctions causing damage to or loss of embryos could occur. I/We agree that neither LPCH nor Stanford University shall be liable for any loss, destruction, damage or improper freezing, maintenance, storage, withdrawal, thawing, and/or delivery of embryos, whether caused by or resulting from any malfunction of the equipment, failure of utilities, natural disaster, physical disturbance or otherwise; provided, however, that such loss, destruction, damage or improper handling is not caused by the negligence or willful misconduct of LPCH or Stanford University.

If I/we should [both] die or become permanently incapable of determining the fate of my/our stored frozen embryos or if I/we fail to pay the fees for storage, LPCH will no longer be responsible for storing the embryos, and will handle them in accordance with my/our direction in the Advanced Written Directive attached to this Consent.

LPCH reserves the right to terminate its embryo cryostorage program at any time. In the event of such termination, LPCH will provide at least three (3) months prior notice to allow me/us to identify another facility willing to accept the frozen embryos for storage. In the event that arrangements for transfer of the embryos to another facility are not made during such notice period, and in the absence of other contrary written instructions from me/us, I/we hereby authorize LPCH to transfer any embryos of mine/ours to another facility or to take any other actions with respect to the embryos permitted under applicable law.

II. Description of Embryo Transfer and Related Procedures, Risks and Side Effects

A. Initial Testing.

I/We understand that comprehensive medical information will be obtained from me/us, from medical records, from physical examinations and otherwise, to determine whether I/we am/are suitable candidate(s) for this procedure. I/We understand that I/we will be tested for Rh factor incompatibility and infectious and sexually transmitted diseases. These tests, and others, may require samples of blood, semen, cervical mucous or cells.

B. Thawing of Embryos/Oocytes.

The oocytes or embryos are stored in "straws" that contain multiple oocytes or embryos. One or more straws will be thawed for transfer according to my/our directive, after consultation with the Intended Parent's or gestational carrier's treating physician. The number of embryos chosen for transfer will be based on the goal of optimizing the chance of achieving a pregnancy while minimizing the likelihood of higher order multiple pregnancy. I/We understand that there is no guarantee that any of the embryos will survive the thawing process. I/We hereby agree that any embryos which the Intended Parent's or gestational carrier's treating physician determines to be non-viable or medically unsuitable for transfer will not be transferred to the Intended Parent or a gestational carrier.

C. Preparation of Intended Parent or Gestational Carrier.

The Intended Parent or gestational carrier will receive estrogen to develop the endometrial lining and progesterone to support the lining for a pregnancy. It may be necessary to administer Leuprolide so that the Intended Parent's or gestational carrier's uterus is prepared for implantation at the time selected for transfer. The Intended Parent's or gestational carrier's endometrium may be monitored by measurement of blood hormones, ultrasound measurements and/or endometrial biopsy.

The risks associated with estrogen and progesterone are similar to those involved in taking birth control pills such as bloating, breast tenderness and blood clots. Possible side effects of Leuprolide are hot flashes, vaginal dryness, insomnia, redness and small bruises at the injection site. Rare cases of allergic reactions at the injection sites also have been reported. Risks of endometrial biopsy include infection, uterine perforation and hemorrhage. Estrogens can cause blood clots, endometrial cancer, gall stones, and other side effects including but not limited to breast tenderness and vaginal discharge. Progesterone can be associated with mood changes (e.g.,depression), bloating and gastrointestinal disturbances.

D. Embryo Transfer.

One or more embryos are transferred into the Intended Parent's or gestational carrier's uterus through a thin catheter (hollow tube) threaded through the cervix. This procedure does not require anesthesia or any pain medication, but may cause mild cramping or discomfort as the catheter passes through the cervix.

II. Description of Embryo Transfer and Related Procedures, Risks and Side Effects

A. Initial Testing.

I/We understand that comprehensive medical information will be obtained from me/us, from medical records, from physical examinations and otherwise, to determine whether I/we am/are suitable candidate(s) for this procedure. I/We understand that I/we will be tested for Rh factor incompatibility and infectious and sexually transmitted diseases. These tests, and others, may require samples of blood, semen, cervical mucous or cells.

B. Thawing of Embryos/Oocytes.

The oocytes or embryos are stored in "straws" that contain multiple oocytes or embryos. One or more straws will be thawed for transfer according to my/our directive, after consultation with the Intended Parent's or gestational carrier's treating physician. The number of embryos chosen for transfer will be based on the goal of optimizing the chance of achieving a pregnancy while minimizing the likelihood of higher order multiple pregnancy. I/We understand that there is no guarantee that any of the embryos will survive the thawing process. I/We hereby agree that any embryos which the Intended Parent's or gestational carrier's treating physician determines to be non-viable or medically unsuitable for transfer will not be transferred to the Intended Parent or a gestational carrier.

C. Preparation of Intended Parent or Gestational Carrier.

The Intended Parent or gestational carrier will receive estrogen to develop the endometrial lining and progesterone to support the lining for a pregnancy. It may be necessary to administer Leuprolide so that the Intended Parent's or gestational carrier's uterus is prepared for implantation at the time selected for transfer. The Intended Parent's or gestational carrier's endometrium may be monitored by measurement of blood hormones, ultrasound measurements and/or endometrial biopsy.

The risks associated with estrogen and progesterone are similar to those involved in taking birth control pills such as bloating, breast tenderness and blood clots. Possible side effects of Leuprolide are hot flashes, vaginal dryness, insomnia, redness and small bruises at the injection site. Rare cases of allergic reactions at the injection sites also have been reported. Risks of endometrial biopsy include infection, uterine perforation and hemorrhage. Estrogens can cause blood clots, endometrial cancer, gall stones, and other side effects including but not limited to breast tenderness and vaginal discharge. Progesterone can be associated with mood changes (e.g.,depression), bloating and gastrointestinal disturbances.

D. Embryo Transfer.

One or more embryos are transferred into the Intended Parent's or gestational carrier's uterus through a thin catheter (hollow tube) threaded through the cervix. This procedure does not require anesthesia or any pain medication, but may cause mild cramping or discomfort as the catheter passes through the cervix.

II. Description of Embryo Transfer and Related Procedures, Risks and Side Effects

A. Initial Testing.

I/We understand that comprehensive medical information will be obtained from me/us, from medical records, from physical examinations and otherwise, to determine whether I/we am/are suitable candidate(s) for this procedure. I/We understand that I/we will be tested for Rh factor incompatibility and infectious and sexually transmitted diseases. These tests, and others, may require samples of blood, semen, cervical mucous or cells.

B. Thawing of Embryos/Oocytes.

The oocytes or embryos are stored in "straws" that contain multiple oocytes or embryos. One or more straws will be thawed for transfer according to my/our directive, after consultation with the Intended Parent's or gestational carrier's treating physician. The number of embryos chosen for transfer will be based on the goal of optimizing the chance of achieving a pregnancy while minimizing the likelihood of higher order multiple pregnancy. I/We understand that there is no guarantee that any of the embryos will survive the thawing process. I/We hereby agree that any embryos which the Intended Parent's or gestational carrier's treating physician determines to be non-viable or medically unsuitable for transfer will not be transferred to the Intended Parent or a gestational carrier.

C. Preparation of Intended Parent or Gestational Carrier.

The Intended Parent or gestational carrier will receive estrogen to develop the endometrial lining and progesterone to support the lining for a pregnancy. It may be necessary to administer Leuprolide so that the Intended Parent's or gestational carrier's uterus is prepared for implantation at the time selected for transfer. The Intended Parent's or gestational carrier's endometrium may be monitored by measurement of blood hormones, ultrasound measurements and/or endometrial biopsy.

The risks associated with estrogen and progesterone are similar to those involved in taking birth control pills such as bloating, breast tenderness and blood clots. Possible side effects of Leuprolide are hot flashes, vaginal dryness, insomnia, redness and small bruises at the injection site. Rare cases of allergic reactions at the injection sites also have been reported. Risks of endometrial biopsy include infection, uterine perforation and hemorrhage. Estrogens can cause blood clots, endometrial cancer, gall stones, and other side effects including but not limited to breast tenderness and vaginal discharge. Progesterone can be associated with mood changes (e.g.,depression), bloating and gastrointestinal disturbances.

D. Embryo Transfer.

One or more embryos are transferred into the Intended Parent's or gestational carrier's uterus through a thin catheter (hollow tube) threaded through the cervix. This procedure does not require anesthesia or any pain medication, but may cause mild cramping or discomfort as the catheter passes through the cervix.

Possible risks of the embryo transfer include loss of the embryos during the laboratory procedures and damage to the uterus, including perforation of the uterus by the catheter or infection in the uterus following the procedure. A fever may be a sign of infection. Allergic reaction also can occur. Each of these is rare.

I/We understand that the treating physician and LPCH are not obligated to perform any procedure that they believe is inconsistent with medical ethics or the standards of appropriate clinical care.

E. Other Risks Associated with Embryo Donation and Pregnancy.

1. The donated embryos may not result in a pregnancy. The success of the embryo transfer cannot be guaranteed. Any of the following may prevent pregnancy: 1) the embryo(s) may not be suitable for transfer; the embryo(s) may become damaged in the laboratory; 3) transfer of embryo(s) may not be successful; 4) the Intended Parent's or gestational carrier's endometrium may not develop properly or the endometrium may not be receptive to the embryo(s); 5) implantation may not occur; 6) the embryo(s) may fail to grow in the uterus; or 7) other unforeseen circumstances may occur. I/We understand that development of pregnancy is dependent on many factors, some of which cannot be tested or predicted in advance, and no guarantees of pregnancy rates can be given.
2. Multiple births. Twin or multiple pregnancy is possible if more than one embryo is transferred into the uterus. Multiple pregnancies carry with them increased risks of miscarriages, premature labor, diabetes in pregnancy, pregnancy-induced hypertension (high blood pressure) and increased financial and emotional costs. A premature newborn may die or have to stay in a special care nursery for a long period of time and may develop a variety of complications, some of which may result in permanent damage. If complications arise from a multiple pregnancy, the treating physician may advise a selective reduction of the number of fetuses. The Intended Parent retains the right at all times to decline any medical recommendation regarding selective reduction.

F. Partial Zona Dissection (Assisted Hatching).

Assisted Hatching ("AH") is a method of treatment to increase the ability of the embryo to hatch from the shell, in the hope of assisting implantation. AH involves micromanipulation of the embryos through enzymatic digestion of a portion of the zona pellucida about one hour prior to the embryo transfer. There is a risk of damage to the embryos during this micromanipulation procedure. If an embryo is damaged, it will not be transferred to the Recipient.

G. Complications of Pregnancy.

If pregnancy is achieved through the embryo transfer, there are risks of miscarriage, genetic defects, birth defects or stillbirths. There are many medical risks to both the pregnant woman and the fetus that are inherent in all pregnancies, whether occurring through intercourse or

Possible risks of the embryo transfer include loss of the embryos during the laboratory procedures and damage to the uterus, including perforation of the uterus by the catheter or infection in the uterus following the procedure. A fever may be a sign of infection. Allergic reaction also can occur. Each of these is rare.

I/We understand that the treating physician and LPCH are not obligated to perform any procedure that they believe is inconsistent with medical ethics or the standards of appropriate clinical care.

E. Other Risks Associated with Embryo Donation and Pregnancy.

1. The donated embryos may not result in a pregnancy. The success of the embryo transfer cannot be guaranteed. Any of the following may prevent pregnancy: 1) the embryo(s) may not be suitable for transfer; the embryo(s) may become damaged in the laboratory; 3) transfer of embryo(s) may not be successful; 4) the Intended Parent's or gestational carrier's endometrium may not develop properly or the endometrium may not be receptive to the embryo(s); 5) implantation may not occur; 6) the embryo(s) may fail to grow in the uterus; or 7) other unforeseen circumstances may occur. I/We understand that development of pregnancy is dependent on many factors, some of which cannot be tested or predicted in advance, and no guarantees of pregnancy rates can be given.

2. Multiple births. Twin or multiple pregnancy is possible if more than one embryo is transferred into the uterus. Multiple pregnancies carry with them increased risks of miscarriages, premature labor, diabetes in pregnancy, pregnancy-induced hypertension (high blood pressure) and increased financial and emotional costs. A premature newborn may die or have to stay in a special care nursery for a long period of time and may develop a variety of complications, some of which may result in permanent damage. If complications arise from a multiple pregnancy, the treating physician may advise a selective reduction of the number of fetuses. The Intended Parent retains the right at all times to decline any medical recommendation regarding selective reduction.

F. Partial Zona Dissection (Assisted Hatching).

Assisted Hatching ("AH") is a method of treatment to increase the ability of the embryo to hatch from the shell, in the hope of assisting implantation. AH involves micromanipulation of the embryos through enzymatic digestion of a portion of the zona pellucida about one hour prior to the embryo transfer. There is a risk of damage to the embryos during this micromanipulation procedure. If an embryo is damaged, it will not be transferred to the Recipient.

G. Complications of Pregnancy.

If pregnancy is achieved through the embryo transfer, there are risks of miscarriage, genetic defects, birth defects or stillbirths. There are many medical risks to both the pregnant woman and the fetus that are inherent in all pregnancies, whether occurring through intercourse or

Possible risks of the embryo transfer include loss of the embryos during the laboratory procedures and damage to the uterus, including perforation of the uterus by the catheter or infection in the uterus following the procedure. A fever may be a sign of infection. Allergic reaction also can occur. Each of these is rare.

I/We understand that the treating physician and LPCH are not obligated to perform any procedure that they believe is inconsistent with medical ethics or the standards of appropriate clinical care.

E. Other Risks Associated with Embryo Donation and Pregnancy.

1. The donated embryos may not result in a pregnancy. The success of the embryo transfer cannot be guaranteed. Any of the following may prevent pregnancy: 1) the embryo(s) may not be suitable for transfer; the embryo(s) may become damaged in the laboratory; 3) transfer of embryo(s) may not be successful; 4) the Intended Parent's or gestational carrier's endometrium may not develop properly or the endometrium may not be receptive to the embryo(s); 5) implantation may not occur; 6) the embryo(s) may fail to grow in the uterus; or 7) other unforeseen circumstances may occur. I/We understand that development of pregnancy is dependent on many factors, some of which cannot be tested or predicted in advance, and no guarantees of pregnancy rates can be given.

2. Multiple births. Twin or multiple pregnancy is possible if more than one embryo is transferred into the uterus. Multiple pregnancies carry with them increased risks of miscarriages, premature labor, diabetes in pregnancy, pregnancy-induced hypertension (high blood pressure) and increased financial and emotional costs. A premature newborn may die or have to stay in a special care nursery for a long period of time and may develop a variety of complications, some of which may result in permanent damage. If complications arise from a multiple pregnancy, the treating physician may advise a selective reduction of the number of fetuses. The Intended Parent retains the right at all times to decline any medical recommendation regarding selective reduction.

F. Partial Zona Dissection (Assisted Hatching).

Assisted Hatching ("AH") is a method of treatment to increase the ability of the embryo to hatch from the shell, in the hope of assisting implantation. AH involves micromanipulation of the embryos through enzymatic digestion of a portion of the zona pellucida about one hour prior to the embryo transfer. There is a risk of damage to the embryos during this micromanipulation procedure. If an embryo is damaged, it will not be transferred to the Recipient.

G. Complications of Pregnancy.

If pregnancy is achieved through the embryo transfer, there are risks of miscarriage, genetic defects, birth defects or stillbirths. There are many medical risks to both the pregnant woman and the fetus that are inherent in all pregnancies, whether occurring through intercourse or

through an embryo transfer. Pregnancy complications, which may include, without limitation, high blood pressure, diabetes, liver disease, hemorrhage or seizures, may lead to serious, permanent impairment to health or function or to death.

H. Abnormalities and Birth Defects

To date, there is no evidence that embryo transfer causes an increased chance of abnormalities in the baby. The risk of birth defects may or may not be higher than the usual risk of birth defects (2 to 5%) when conception occurs following intercourse. Synthetic progesterone has been linked to an increase in certain forms of fetal abnormalities. LPCH prescribes natural forms of progesterone which have not been associated with such increases in fetal abnormalities.

I. Psychological Risks.

The psychological and emotional risks to the Intended Parent(s) and their family of using donated embryo(s) to have a child are unknown.

J. Privacy of Medical Information.

I/We understand that it may be necessary for my physician to keep certain records as part of the hospital record concerning the source and disposition of donated embryos. LPCH protects the privacy of medical information in accordance with state and federal legal requirements and the LPCH Notice of Privacy Practices (which I/we have received). I/We agree that medical details related to the embryo transfer may be revealed in professional publications, as long as my/our anonymity is preserved.

I/We also understand that LPCH, in keeping with federal regulations, sends data (and agrees to permit these data to be verified by audit) to the federal Centers for Disease Control and Prevention ("CDC") national registry, which is maintained by the Society for Assisted Reproductive Technology, an affiliate of the American Society for Reproductive Medicine. The 1992 Fertility Clinic Success Rate and Certification Act requires that the CDC collect data on all assisted reproductive technology cycles performed in the United State annually and report success rates using these data. LPCH may provide my/our identifying information including but not limited to name(s) or social security number(s) to the CDC in connection with such required reporting. Because sensitive information will be collected by the CDC, the CDC has obtained an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). It is also possible that at some time in the future, information regarding the treatment of a particular Recipient with a donated embryo including but not limited to health and other information that identifies you could be part of a governmental audit of LPCH by other governmental entities such as the United States Department of Health and Human Services, the California Department of Public Health or the California Health and Human Services Agency. Any such audit may include, but not be limited to, examination of medical and laboratory records and comparison of the data in the medical records with the data in governmental reporting databases.

through an embryo transfer. Pregnancy complications, which may include, without limitation, high blood pressure, diabetes, liver disease, hemorrhage or seizures, may lead to serious, permanent impairment to health or function or to death.

H. Abnormalities and Birth Defects

To date, there is no evidence that embryo transfer causes an increased chance of abnormalities in the baby. The risk of birth defects may or may not be higher than the usual risk of birth defects (2 to 5%) when conception occurs following intercourse. Synthetic progesterone has been linked to an increase in certain forms of fetal abnormalities. LPCH prescribes natural forms of progesterone which have not been associated with such increases in fetal abnormalities.

I. Psychological Risks.

The psychological and emotional risks to the Intended Parent(s) and their family of using donated embryo(s) to have a child are unknown.

J. Privacy of Medical Information.

I/We understand that it may be necessary for my physician to keep certain records as part of the hospital record concerning the source and disposition of donated embryos. LPCH protects the privacy of medical information in accordance with state and federal legal requirements and the LPCH Notice of Privacy Practices (which I/we have received). I/We agree that medical details related to the embryo transfer may be revealed in professional publications, as long as my/our anonymity is preserved.

I/We also understand that LPCH, in keeping with federal regulations, sends data (and agrees to permit these data to be verified by audit) to the federal Centers for Disease Control and Prevention ("CDC") national registry, which is maintained by the Society for Assisted Reproductive Technology, an affiliate of the American Society for Reproductive Medicine. The 1992 Fertility Clinic Success Rate and Certification Act requires that the CDC collect data on all assisted reproductive technology cycles performed in the United State annually and report success rates using these data. LPCH may provide my/our identifying information including but not limited to name(s) or social security number(s) to the CDC in connection with such required reporting. Because sensitive information will be collected by the CDC, the CDC has obtained an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). It is also possible that at some time in the future, information regarding the treatment of a particular Recipient with a donated embryo including but not limited to health and other information that identifies you could be part of a governmental audit of LPCH by other governmental entities such as the United States Department of Health and Human Services, the California Department of Public Health or the California Health and Human Services Agency. Any such audit may include, but not be limited to, examination of medical and laboratory records and comparison of the data in the medical records with the data in governmental reporting databases.

through an embryo transfer. Pregnancy complications, which may include, without limitation, high blood pressure, diabetes, liver disease, hemorrhage or seizures, may lead to serious, permanent impairment to health or function or to death.

H. Abnormalities and Birth Defects

To date, there is no evidence that embryo transfer causes an increased chance of abnormalities in the baby. The risk of birth defects may or may not be higher than the usual risk of birth defects (2 to 5%) when conception occurs following intercourse. Synthetic progesterone has been linked to an increase in certain forms of fetal abnormalities. LPCH prescribes natural forms of progesterone which have not been associated with such increases in fetal abnormalities.

I. Psychological Risks.

The psychological and emotional risks to the Intended Parent(s) and their family of using donated embryo(s) to have a child are unknown.

J. Privacy of Medical Information.

I/We understand that it may be necessary for my physician to keep certain records as part of the hospital record concerning the source and disposition of donated embryos. LPCH protects the privacy of medical information in accordance with state and federal legal requirements and the LPCH Notice of Privacy Practices (which I/we have received). I/We agree that medical details related to the embryo transfer may be revealed in professional publications, as long as my/our anonymity is preserved.

I/We also understand that LPCH, in keeping with federal regulations, sends data (and agrees to permit these data to be verified by audit) to the federal Centers for Disease Control and Prevention ("CDC") national registry, which is maintained by the Society for Assisted Reproductive Technology, an affiliate of the American Society for Reproductive Medicine. The 1992 Fertility Clinic Success Rate and Certification Act requires that the CDC collect data on all assisted reproductive technology cycles performed in the United State annually and report success rates using these data. LPCH may provide my/our identifying information including but not limited to name(s) or social security number(s) to the CDC in connection with such required reporting. Because sensitive information will be collected by the CDC, the CDC has obtained an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). It is also possible that at some time in the future, information regarding the treatment of a particular Recipient with a donated embryo including but not limited to health and other information that identifies you could be part of a governmental audit of LPCH by other governmental entities such as the United States Department of Health and Human Services, the California Department of Public Health or the California Health and Human Services Agency. Any such audit may include, but not be limited to, examination of medical and laboratory records and comparison of the data in the medical records with the data in governmental reporting databases.

III. Legal and Financial Matters

A. Legal Status.

I/We understand that the legal status of embryos is as yet uncertain and that there may be future changes in the law that affect the ownership and rights to embryos and child(ren) that develop from embryos. I/We have had an opportunity to seek independent counsel about issues related to custody or ownership of embryos, parental rights and responsibilities, inheritance rights and any other legal concerns I/we may have with respect to the donation and transfer of embryos.

B. Release of Liability.

I/We hereby release LPCH, Stanford University and their respective officers, directors, employees and agents, from (i) any medical, psychological, emotional or legal damage related to my/our voluntary participation in the embryo program and (ii) any damage or loss of the embryos; provided, however, that such damage or loss is not caused solely by negligence or willful misconduct on the part of LPCH or Stanford University.

C. Financial Responsibility.

I/We understand that I/we are solely financially responsible for the costs of all services and items provided by LPCH as part of the embryo donation and transfer process, including, to the extent applicable, (i) medical costs of the Donors not otherwise paid by the Donors, LPCH or an Agency and (ii) embryo storage costs. I/We further understand that I/we are responsible for the costs of all services and items provided by LPCH, Stanford University or their physicians in connection with the embryo donation and transfer, including treatment of any medical complications experienced by the Intended Parent or a gestational carrier as a result of the embryo transfer, to the extent such services and items are not covered by the Intended Parent's medical insurance or are not paid for by, to the extent applicable, Agency. I/We have received LPCH's Schedule of Fees and have had the opportunity to meet with a financial counselor.

I/We understand that LPCH is not responsible for any costs related to the embryo donation and transfer or any related medical complications, should they occur. I/We understand that LPCH, in its sole discretion, may arrange for insurance to cover certain costs related to medical complications which I (the Intended Parent) or gestational carrier may experience, and that I/we will be solely financially responsible for any applicable premium for such insurance. Notwithstanding the foregoing, I (the Intended Parent) shall not be required to pay the premium for any insurance policy arranged by LPCH to cover me or the gestational carrier, provided I provide evidence of comparable coverage which is reasonably satisfactory to LPCH. I (Intended Parent) certify that I have the following medical insurance, which will cover any medical complications I experience:

____

Name of Member, Carrier, Policy Number, and Group Name

III. Legal and Financial Matters

A. Legal Status.

I/We understand that the legal status of embryos is as yet uncertain and that there may be future changes in the law that affect the ownership and rights to embryos and child(ren) that develop from embryos. I/We have had an opportunity to seek independent counsel about issues related to custody or ownership of embryos, parental rights and responsibilities, inheritance rights and any other legal concerns I/we may have with respect to the donation and transfer of embryos.

B. Release of Liability.

I/We hereby release LPCH, Stanford University and their respective officers, directors, employees and agents, from (i) any medical, psychological, emotional or legal damage related to my/our voluntary participation in the embryo program and (ii) any damage or loss of the embryos; provided, however, that such damage or loss is not caused solely by negligence or willful misconduct on the part of LPCH or Stanford University.

C. Financial Responsibility.

I/We understand that I/we are solely financially responsible for the costs of all services and items provided by LPCH as part of the embryo donation and transfer process, including, to the extent applicable, (i) medical costs of the Donors not otherwise paid by the Donors, LPCH or an Agency and (ii) embryo storage costs. I/We further understand that I/we are responsible for the costs of all services and items provided by LPCH, Stanford University or their physicians in connection with the embryo donation and transfer, including treatment of any medical complications experienced by the Intended Parent or a gestational carrier as a result of the embryo transfer, to the extent such services and items are not covered by the Intended Parent's medical insurance or are not paid for by, to the extent applicable, Agency. I/We have received LPCH's Schedule of Fees and have had the opportunity to meet with a financial counselor.

I/We understand that LPCH is not responsible for any costs related to the embryo donation and transfer or any related medical complications, should they occur. I/We understand that LPCH, in its sole discretion, may arrange for insurance to cover certain costs related to medical complications which I (the Intended Parent) or gestational carrier may experience, and that I/we will be solely financially responsible for any applicable premium for such insurance. Notwithstanding the foregoing, I (the Intended Parent) shall not be required to pay the premium for any insurance policy arranged by LPCH to cover me or the gestational carrier, provided I provide evidence of comparable coverage which is reasonably satisfactory to LPCH. I (Intended Parent) certify that I have the following medical insurance, which will cover any medical complications I experience:

____

Name of Member, Carrier, Policy Number, and Group Name

III. Legal and Financial Matters

A. Legal Status.

I/We understand that the legal status of embryos is as yet uncertain and that there may be future changes in the law that affect the ownership and rights to embryos and child(ren) that develop from embryos. I/We have had an opportunity to seek independent counsel about issues related to custody or ownership of embryos, parental rights and responsibilities, inheritance rights and any other legal concerns I/we may have with respect to the donation and transfer of embryos.

B. Release of Liability.

I/We hereby release LPCH, Stanford University and their respective officers, directors, employees and agents, from (i) any medical, psychological, emotional or legal damage related to my/our voluntary participation in the embryo program and (ii) any damage or loss of the embryos; provided, however, that such damage or loss is not caused solely by negligence or willful misconduct on the part of LPCH or Stanford University.

C. Financial Responsibility.

I/We understand that I/we are solely financially responsible for the costs of all services and items provided by LPCH as part of the embryo donation and transfer process, including, to the extent applicable, (i) medical costs of the Donors not otherwise paid by the Donors, LPCH or an Agency and (ii) embryo storage costs. I/We further understand that I/we are responsible for the costs of all services and items provided by LPCH, Stanford University or their physicians in connection with the embryo donation and transfer, including treatment of any medical complications experienced by the Intended Parent or a gestational carrier as a result of the embryo transfer, to the extent such services and items are not covered by the Intended Parent's medical insurance or are not paid for by, to the extent applicable, Agency. I/We have received LPCH's Schedule of Fees and have had the opportunity to meet with a financial counselor.

I/We understand that LPCH is not responsible for any costs related to the embryo donation and transfer or any related medical complications, should they occur. I/We understand that LPCH, in its sole discretion, may arrange for insurance to cover certain costs related to medical complications which I (the Intended Parent) or gestational carrier may experience, and that I/we will be solely financially responsible for any applicable premium for such insurance. Notwithstanding the foregoing, I (the Intended Parent) shall not be required to pay the premium for any insurance policy arranged by LPCH to cover me or the gestational carrier, provided I provide evidence of comparable coverage which is reasonably satisfactory to LPCH. I (Intended Parent) certify that I have the following medical insurance, which will cover any medical complications I experience:

____

Name of Member, Carrier, Policy Number, and Group Name

I/We understand that we will be responsible for payment of long-term storage fees to LPCH of any donated embryos that are not transferred. If a storage fee remains unpaid for _____ days, then and in that event, after no fewer than _____ days advance notice to us through certified U.S. mail to our last known address, but without further consent or authorization on our part, the frozen embryos will be shipped to a proper location in accordance with my/our Advanced Written Directive.

IV. Consents *(initial below)*

A. Consent to Oocyte or Embryo Thawing.

Recipient Partner

________ _________ I/We request, authorize and consent to the thawing and utilization of frozen oocytes or embryos in accordance with the plan for embryo transfer agreed upon with the Intended Parent's or gestational carrier's treating physician.

B. Consent to Embryo Transfer

_____ I (the "Recipient") authorize ______________________________, M.D. to perform the embryo transfer, including the related physical examinations and tests. I understand that I will be tested for infectious and sexually transmitted diseases. These tests, and others, may require samples of blood, semen, cervical mucous or cells. I understand that any procedure may involve the risk of an unsuccessful result or complication. I understand I have the right to be informed about my proposed care, treatment, medications, interventions, procedures and their risks, benefits, side effects, potential problems related to recuperation, and the likelihood of achieving my treatment goals. Except in an emergency, a procedure is not performed until I have had the opportunity to receive this information and give my consent. I understand in an emergency that different or additional procedures may be required if my treating physician believes they are necessary. I also understand that other medical care at LPCH will not be withheld if I decide to withhold or withdraw my consent for the embryo transfer or related procedures.

C. Consent to Assisted Hatching.

Recipient Partner

________ _________ I/We consent to the performance of Partial Zona Dissection (Assisted Hatching or AH) if medically indicated as treatment to increase the ability of the embryo to hatch from the shell.

I/We understand that we will be responsible for payment of long-term storage fees to LPCH of any donated embryos that are not transferred. If a storage fee remains unpaid for _____ days, then and in that event, after no fewer than _____ days advance notice to us through certified U.S. mail to our last known address, but without further consent or authorization on our part, the frozen embryos will be shipped to a proper location in accordance with my/our Advanced Written Directive.

IV. Consents *(initial below)*

A. Consent to Oocyte or Embryo Thawing.

Recipient Partner

________ _________ I/We request, authorize and consent to the thawing and utilization of frozen oocytes or embryos in accordance with the plan for embryo transfer agreed upon with the Intended Parent's or gestational carrier's treating physician.

B. Consent to Embryo Transfer

_____ I (the "Recipient") authorize ______________________________, M.D. to perform the embryo transfer, including the related physical examinations and tests. I understand that I will be tested for infectious and sexually transmitted diseases. These tests, and others, may require samples of blood, semen, cervical mucous or cells. I understand that any procedure may involve the risk of an unsuccessful result or complication. I understand I have the right to be informed about my proposed care, treatment, medications, interventions, procedures and their risks, benefits, side effects, potential problems related to recuperation, and the likelihood of achieving my treatment goals. Except in an emergency, a procedure is not performed until I have had the opportunity to receive this information and give my consent. I understand in an emergency that different or additional procedures may be required if my treating physician believes they are necessary. I also understand that other medical care at LPCH will not be withheld if I decide to withhold or withdraw my consent for the embryo transfer or related procedures.

C. Consent to Assisted Hatching.

Recipient Partner

________ _________ I/We consent to the performance of Partial Zona Dissection (Assisted Hatching or AH) if medically indicated as treatment to increase the ability of the embryo to hatch from the shell.

I/We understand that we will be responsible for payment of long-term storage fees to LPCH of any donated embryos that are not transferred. If a storage fee remains unpaid for _____ days, then and in that event, after no fewer than _____ days advance notice to us through certified U.S. mail to our last known address, but without further consent or authorization on our part, the frozen embryos will be shipped to a proper location in accordance with my/our Advanced Written Directive.

IV. Consents *(initial below)*

A. Consent to Oocyte or Embryo Thawing.

Recipient	Partner	
________	_________	I/We request, authorize and consent to the thawing and utilization of frozen oocytes or embryos in accordance with the plan for embryo transfer agreed upon with the Intended Parent's or gestational carrier's treating physician.

B. Consent to Embryo Transfer

_____ I (the "Recipient") authorize ______________________________, M.D. to perform the embryo transfer, including the related physical examinations and tests. I understand that I will be tested for infectious and sexually transmitted diseases. These tests, and others, may require samples of blood, semen, cervical mucous or cells. I understand that any procedure may involve the risk of an unsuccessful result or complication. I understand I have the right to be informed about my proposed care, treatment, medications, interventions, procedures and their risks, benefits, side effects, potential problems related to recuperation, and the likelihood of achieving my treatment goals. Except in an emergency, a procedure is not performed until I have had the opportunity to receive this information and give my consent. I understand in an emergency that different or additional procedures may be required if my treating physician believes they are necessary. I also understand that other medical care at LPCH will not be withheld if I decide to withhold or withdraw my consent for the embryo transfer or related procedures.

C. Consent to Assisted Hatching.

Recipient	Partner	
________	_________	I/We consent to the performance of Partial Zona Dissection (Assisted Hatching or AH) if medically indicated as treatment to increase the ability of the embryo to hatch from the shell.

D. Consent to Disposition of Unused Donated Embryos or Oocytes.

I/We acknowledge that our ability to control the disposition of the donated embryos after completion of treatment by LPCH, is governed by the terms and conditions of, to the extent applicable, the Donor Consent or the Agency Attestation in addition to my/our Advanced Written Directive. I/We consent to:

Recipient	Partner	
________	________	LPCH's refreezing of thawed embryos that are not transferred.
________	________	LPCH's disposition of surplus embryos in accordance with my/our Advanced Written Directive in the event of: (i) my death or, if applicable, my partner's death, (ii) divorce or separation or (iii) my/our abandonment of such embryos.
________	________	Under any circumstances not governed by my/our Advanced Written Directive, LPCH's disposition and use of such embryos for any of the following purposes: (i) quality assurance and quality improvement, (ii) education and training, (iii) future research purposes or studies, which may include genetic testing, unless I/we affirmatively opt out of future research uses of the donated embryos pursuant to the Opt Out from Future Research Uses below and/or (iv) future reproductive assistance for other LPCH patients.

Opt Out from Future Research Uses (optional): *I/We hereby opt out of LPCH's use of, or anyone else's use of, the donated embryos for research purposes. By signing below, I/we understand that the donated embryos will not be used for research purposes.*

*Signature of Intended Parent:*______________________________

*Signature of Intended Parent's partner (if applicable):*______________________________

I/We understand that we may elect to have frozen embryos shipped to another storage bank or location at my/our sole cost, it being understood that the responsibility for locating such an alternate storage bank rests solely with me/us, and not LPCH.

We understand that the embryos are considered the joint property of both of us and that, except as permitted by the Advanced Written Directive or expressly stated in this Consent, LPCH will require written consent from both of us or, alternatively, a direction contained in a property settlement agreement executed by each of us or an order from a court with proper jurisdiction, before LPCH will release the embryos to one of us or another person.

D. Consent to Disposition of Unused Donated Embryos or Oocytes.

I/We acknowledge that our ability to control the disposition of the donated embryos after completion of treatment by LPCH, is governed by the terms and conditions of, to the extent applicable, the Donor Consent or the Agency Attestation in addition to my/our Advanced Written Directive. I/We consent to:

Recipient	Partner	
________	________	LPCH's refreezing of thawed embryos that are not transferred.
________	________	LPCH's disposition of surplus embryos in accordance with my/our Advanced Written Directive in the event of: (i) my death or, if applicable, my partner's death, (ii) divorce or separation or (iii) my/our abandonment of such embryos.
________	________	Under any circumstances not governed by my/our Advanced Written Directive, LPCH's disposition and use of such embryos for any of the following purposes: (i) quality assurance and quality improvement, (ii) education and training, (iii) future research purposes or studies, which may include genetic testing, unless I/we affirmatively opt out of future research uses of the donated embryos pursuant to the Opt Out from Future Research Uses below and/or (iv) future reproductive assistance for other LPCH patients.

Opt Out from Future Research Uses (optional): *I/We hereby opt out of LPCH's use of, or anyone else's use of, the donated embryos for research purposes. By signing below, I/we understand that the donated embryos will not be used for research purposes.*

*Signature of Intended Parent:*____

*Signature of Intended Parent's partner (if applicable):*__________________________

I/We understand that we may elect to have frozen embryos shipped to another storage bank or location at my/our sole cost, it being understood that the responsibility for locating such an alternate storage bank rests solely with me/us, and not LPCH.

We understand that the embryos are considered the joint property of both of us and that, except as permitted by the Advanced Written Directive or expressly stated in this Consent, LPCH will require written consent from both of us or, alternatively, a direction contained in a property settlement agreement executed by each of us or an order from a court with proper jurisdiction, before LPCH will release the embryos to one of us or another person.

D. Consent to Disposition of Unused Donated Embryos or Oocytes.

I/We acknowledge that our ability to control the disposition of the donated embryos after completion of treatment by LPCH, is governed by the terms and conditions of, to the extent applicable, the Donor Consent or the Agency Attestation in addition to my/our Advanced Written Directive. I/We consent to:

Recipient	Partner	
________	________	LPCH's refreezing of thawed embryos that are not transferred.
________	________	LPCH's disposition of surplus embryos in accordance with my/our Advanced Written Directive in the event of: (i) my death or, if applicable, my partner's death, (ii) divorce or separation or (iii) my/our abandonment of such embryos.
________	________	Under any circumstances not governed by my/our Advanced Written Directive, LPCH's disposition and use of such embryos for any of the following purposes: (i) quality assurance and quality improvement, (ii) education and training, (iii) future research purposes or studies, which may include genetic testing, unless I/we affirmatively opt out of future research uses of the donated embryos pursuant to the Opt Out from Future Research Uses below and/or (iv) future reproductive assistance for other LPCH patients.

Opt Out from Future Research Uses (optional): *I/We hereby opt out of LPCH's use of, or anyone else's use of, the donated embryos for research purposes. By signing below, I/we understand that the donated embryos will not be used for research purposes.*

*Signature of Intended Parent:*______________________________

*Signature of Intended Parent's partner (if applicable):*______________________________

I/We understand that we may elect to have frozen embryos shipped to another storage bank or location at my/our sole cost, it being understood that the responsibility for locating such an alternate storage bank rests solely with me/us, and not LPCH.

We understand that the embryos are considered the joint property of both of us and that, except as permitted by the Advanced Written Directive or expressly stated in this Consent, LPCH will require written consent from both of us or, alternatively, a direction contained in a property settlement agreement executed by each of us or an order from a court with proper jurisdiction, before LPCH will release the embryos to one of us or another person.

E. Participation of Additional Practitioners in Procedures

In addition to caring for patients, LPCH is affiliated with the Stanford University School of Medicine. As part of the medical education and training programs, postgraduate fellows, residents, medical students, and other approved health care practitioners may observe care, and if appropriately trained, participate in aspects of the procedure. These practitioners will be under the supervision of the attending doctor. I/We understand and agree that the procedure described in this document will be carried out by the practitioner identified in Section IV(2) of this Consent, along with associates and assistants, including anesthesiologists from the medical staff.

F. Scope of Authorization.

Intended Parent and, if applicable, Intended Parent's Partner consent to the performance of the Medical procedures described in this consent form until the occurrence of one of the following events: (i) death of Intended Parent, (ii) dissolution of Intended Parent's marriage or partnership, if applicable, (iii) Intended Parent's or gestational carrier's successful pregnancy which results in live birth, or (iv) written notice to LPCH of withdrawal of consent by Intended Parent and/or Intended Parent's Partner, if applicable. I/We acknowledge and agree that in the event of dissolution of Intended Parent's marriage or partnership or a live birth, LPCH will require Intended Partner and Intended Parent's Partner, if applicable, to execute a new consent form prior to the performance of any additional medical procedures described herein. Notwithstanding the foregoing, I/we acknowledge and agree that any and all representations, covenants and agreements contained herein shall remain in full force and effect with respect to procedures performed prior to the occurrence of the event and any embryo(s), fetus(es) and/or child(ren) which have resulted from such procedures.

V. Notice Requirements

Intended Parent and, if applicable, Intended Parent's Partner shall provide LPCH written notice of any of the following events no later than thirty (30) days after the occurrence of such event: (i) death of Intended Parent or Intended Parent's Partner; (ii) dissolution of Intended Parent's marriage or partnership; (iii) Intended Parent's or gestational carrier's successful pregnancy which results in live birth, or (iv) Intended Parent or Intended Parent's Partner's change of address. Prior to LPCH's receipt of such written notice, LPCH shall not be deemed to have knowledge of such event nor shall LPCH be liable for any actions taken which may be inconsistent with the occurrence of such event.

If Intended Parent and Intended Parent's Partner are unmarried under the laws of California, we hereby agree that LPCH may both require and rely upon a notarized statement of dissolution of partnership, signed by either the Intended Parent or the Intended Parent's Partner, for the purposes of this Section V.

E. Participation of Additional Practitioners in Procedures

In addition to caring for patients, LPCH is affiliated with the Stanford University School of Medicine. As part of the medical education and training programs, postgraduate fellows, residents, medical students, and other approved health care practitioners may observe care, and if appropriately trained, participate in aspects of the procedure. These practitioners will be under the supervision of the attending doctor. I/We understand and agree that the procedure described in this document will be carried out by the practitioner identified in Section IV(2) of this Consent, along with associates and assistants, including anesthesiologists from the medical staff.

F. Scope of Authorization.

Intended Parent and, if applicable, Intended Parent's Partner consent to the performance of the Medical procedures described in this consent form until the occurrence of one of the following events: (i) death of Intended Parent, (ii) dissolution of Intended Parent's marriage or partnership, if applicable, (iii) Intended Parent's or gestational carrier's successful pregnancy which results in live birth, or (iv) written notice to LPCH of withdrawal of consent by Intended Parent and/or Intended Parent's Partner, if applicable. I/We acknowledge and agree that in the event of dissolution of Intended Parent's marriage or partnership or a live birth, LPCH will require Intended Partner and Intended Parent's Partner, if applicable, to execute a new consent form prior to the performance of any additional medical procedures described herein. Notwithstanding the foregoing, I/we acknowledge and agree that any and all representations, covenants and agreements contained herein shall remain in full force and effect with respect to procedures performed prior to the occurrence of the event and any embryo(s), fetus(es) and/or child(ren) which have resulted from such procedures.

V. Notice Requirements

Intended Parent and, if applicable, Intended Parent's Partner shall provide LPCH written notice of any of the following events no later than thirty (30) days after the occurrence of such event: (i) death of Intended Parent or Intended Parent's Partner; (ii) dissolution of Intended Parent's marriage or partnership; (iii) Intended Parent's or gestational carrier's successful pregnancy which results in live birth, or (iv) Intended Parent or Intended Parent's Partner's change of address. Prior to LPCH's receipt of such written notice, LPCH shall not be deemed to have knowledge of such event nor shall LPCH be liable for any actions taken which may be inconsistent with the occurrence of such event.

If Intended Parent and Intended Parent's Partner are unmarried under the laws of California, we hereby agree that LPCH may both require and rely upon a notarized statement of dissolution of partnership, signed by either the Intended Parent or the Intended Parent's Partner, for the purposes of this Section V.

E. Participation of Additional Practitioners in Procedures

In addition to caring for patients, LPCH is affiliated with the Stanford University School of Medicine. As part of the medical education and training programs, postgraduate fellows, residents, medical students, and other approved health care practitioners may observe care, and if appropriately trained, participate in aspects of the procedure. These practitioners will be under the supervision of the attending doctor. I/We understand and agree that the procedure described in this document will be carried out by the practitioner identified in Section IV(2) of this Consent, along with associates and assistants, including anesthesiologists from the medical staff.

F. Scope of Authorization.

Intended Parent and, if applicable, Intended Parent's Partner consent to the performance of the Medical procedures described in this consent form until the occurrence of one of the following events: (i) death of Intended Parent, (ii) dissolution of Intended Parent's marriage or partnership, if applicable, (iii) Intended Parent's or gestational carrier's successful pregnancy which results in live birth, or (iv) written notice to LPCH of withdrawal of consent by Intended Parent and/or Intended Parent's Partner, if applicable. I/We acknowledge and agree that in the event of dissolution of Intended Parent's marriage or partnership or a live birth, LPCH will require Intended Partner and Intended Parent's Partner, if applicable, to execute a new consent form prior to the performance of any additional medical procedures described herein. Notwithstanding the foregoing, I/we acknowledge and agree that any and all representations, covenants and agreements contained herein shall remain in full force and effect with respect to procedures performed prior to the occurrence of the event and any embryo(s), fetus(es) and/or child(ren) which have resulted from such procedures.

V. Notice Requirements

Intended Parent and, if applicable, Intended Parent's Partner shall provide LPCH written notice of any of the following events no later than thirty (30) days after the occurrence of such event: (i) death of Intended Parent or Intended Parent's Partner; (ii) dissolution of Intended Parent's marriage or partnership; (iii) Intended Parent's or gestational carrier's successful pregnancy which results in live birth, or (iv) Intended Parent or Intended Parent's Partner's change of address. Prior to LPCH's receipt of such written notice, LPCH shall not be deemed to have knowledge of such event nor shall LPCH be liable for any actions taken which may be inconsistent with the occurrence of such event.

If Intended Parent and Intended Parent's Partner are unmarried under the laws of California, we hereby agree that LPCH may both require and rely upon a notarized statement of dissolution of partnership, signed by either the Intended Parent or the Intended Parent's Partner, for the purposes of this Section V.

All notices which are required by this consent form shall be hand-delivered or sent by registered or certified mail, postage prepaid as follows:

If to LPCH:

Lucile Packard Children's Hospital
725 Welch Road
Palo Alto, CA 94304
Attn: ______________________

If to Intended Parent (and, if applicable, Intended Parent's Partner):

____

____

____

All notices shall be deemed received two (2) business days after hand delivery or five (5) business days after mailing in accordance with this Section.

By my signature(s) below, I confirm that:

1. I have read and understood the information present on this form and the nature and purpose of the procedure(s) have been explained to me. The risks and benefits of the procedure(s) have been explained to me. In addition, the alternative treatments and the risks and benefits of these alternatives have been explained to me. I have had the opportunity to ask questions and have received all the information I desire about the procedure(s).
2. I understand that in an emergency, there may be different or further procedure(s) required if the doctor believes they are necessary, and I consent to such procedure(s).
3. I understand that the administration of anesthesia and/or sedation and associated procedures may be necessary to assure safety and comfort during the procedure(s), and I consent to such procedures, if clinically indicated. I understand certain risks and complications (as described earlier in this consent form) may be associated with the use of anesthesia and/or sedation and that the appropriate practitioner will discuss these risks with me prior to the procedure(s).
4. I consent to the taking of ultrasound images and pictures, videotapes, or other electronic reproductions of the embryos and the use of the pictures, videotapes, or electronic reproductions for treatment or internal or external activities consistent with the hospital's mission of education and research, conducted in accordance with hospital policies.
5. I understand that this Consent will be maintained in my medical record and a copy will be provided for me. I understand that this Consent is an important document and should be retained with other vital records.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

All notices which are required by this consent form shall be hand-delivered or sent by registered or certified mail, postage prepaid as follows:

If to LPCH:

Lucile Packard Children's Hospital
725 Welch Road
Palo Alto, CA 94304
Attn: ______________________

If to Intended Parent (and, if applicable, Intended Parent's Partner):

____

____

____

All notices shall be deemed received two (2) business days after hand delivery or five (5) business days after mailing in accordance with this Section.

By my signature(s) below, I confirm that:

1. I have read and understood the information present on this form and the nature and purpose of the procedure(s) have been explained to me. The risks and benefits of the procedure(s) have been explained to me. In addition, the alternative treatments and the risks and benefits of these alternatives have been explained to me. I have had the opportunity to ask questions and have received all the information I desire about the procedure(s).
2. I understand that in an emergency, there may be different or further procedure(s) required if the doctor believes they are necessary, and I consent to such procedure(s).
3. I understand that the administration of anesthesia and/or sedation and associated procedures may be necessary to assure safety and comfort during the procedure(s), and I consent to such procedures, if clinically indicated. I understand certain risks and complications (as described earlier in this consent form) may be associated with the use of anesthesia and/or sedation and that the appropriate practitioner will discuss these risks with me prior to the procedure(s).
4. I consent to the taking of ultrasound images and pictures, videotapes, or other electronic reproductions of the embryos and the use of the pictures, videotapes, or electronic reproductions for treatment or internal or external activities consistent with the hospital's mission of education and research, conducted in accordance with hospital policies.
5. I understand that this Consent will be maintained in my medical record and a copy will be provided for me. I understand that this Consent is an important document and should be retained with other vital records.

All notices which are required by this consent form shall be hand-delivered or sent by registered or certified mail, postage prepaid as follows:

If to LPCH:

Lucile Packard Children's Hospital
725 Welch Road
Palo Alto, CA 94304
Attn: ______________________

If to Intended Parent (and, if applicable, Intended Parent's Partner):

____

____

____

All notices shall be deemed received two (2) business days after hand delivery or five (5) business days after mailing in accordance with this Section.

By my signature(s) below, I confirm that:

1. I have read and understood the information present on this form and the nature and purpose of the procedure(s) have been explained to me. The risks and benefits of the procedure(s) have been explained to me. In addition, the alternative treatments and the risks and benefits of these alternatives have been explained to me. I have had the opportunity to ask questions and have received all the information I desire about the procedure(s).
2. I understand that in an emergency, there may be different or further procedure(s) required if the doctor believes they are necessary, and I consent to such procedure(s).
3. I understand that the administration of anesthesia and/or sedation and associated procedures may be necessary to assure safety and comfort during the procedure(s), and I consent to such procedures, if clinically indicated. I understand certain risks and complications (as described earlier in this consent form) may be associated with the use of anesthesia and/or sedation and that the appropriate practitioner will discuss these risks with me prior to the procedure(s).
4. I consent to the taking of ultrasound images and pictures, videotapes, or other electronic reproductions of the embryos and the use of the pictures, videotapes, or electronic reproductions for treatment or internal or external activities consistent with the hospital's mission of education and research, conducted in accordance with hospital policies.
5. I understand that this Consent will be maintained in my medical record and a copy will be provided for me. I understand that this Consent is an important document and should be retained with other vital records.

6. I consent to the performance of the procedures designated above as well as with the disposition arrangements set forth in this Consent and the attached Advanced Written Directive.

Date	Time	Signature (Intended Parent/Patient)	Print Name	Initials

Date	Time	Signature (Partner)	Print Name	Initials

If this document was interpreted:

Print:______________________________ or______________________________

VMI or in person interpreter name 244 Tel. Interpreter ID Number Date Time

Language:____________________________

_____ Telephone Consent Obtained by Practitioner

Second Witness to Telephone Consent:______________________________

Print Name of Second Witness to Consent: ______________________________

Informed Consent Attestation:

I have discussed the procedures above, including the risks, benefits, and alternatives with the patient and her partner. I have also explained that with any procedure there is always the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any procedure or treatment.

All questions were answered and the patient (and her partner, if applicable) consents to the procedures designated above.

Date	Time	Signature (Title of Practitioner)	Print Name	Pager #

AS REQUIRED UNDER CALIFORNIA STATE LAW, THE ORIGINAL OF THIS CONSENT SHALL BE KEPT IN YOUR MEDICAL RECORD AND A COPY PROVIDED TO YOU FOR YOUR RECORDS AND TO THE HOSPITAL IF THE PROCEDURES ARE PERFORMED IN A HOSPITAL. THIS CONSENT IS AN IMPORTANT DOCUMENT AND SHOULD BE RETAINED WITH OTHER VITAL RECORDS.

6. I consent to the performance of the procedures designated above as well as with the disposition arrangements set forth in this Consent and the attached Advanced Written Directive.

Date	Time	Signature (Intended Parent/Patient)	Print Name	Initials

Date	Time	Signature (Partner)	Print Name	Initials

If this document was interpreted:

Print:____________________________________ or____________________________________

VMI or in person interpreter name   244 Tel. Interpreter ID Number Date Time

Language:______________________________

_____ Telephone Consent Obtained by Practitioner

Second Witness to Telephone Consent:____

Print Name of Second Witness to Consent: ____

Informed Consent Attestation:

I have discussed the procedures above, including the risks, benefits, and alternatives with the patient and her partner. I have also explained that with any procedure there is always the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any procedure or treatment.

All questions were answered and the patient (and her partner, if applicable) consents to the procedures designated above.

Date	Time	Signature (Title of Practitioner)	Print Name	Pager #

AS REQUIRED UNDER CALIFORNIA STATE LAW, THE ORIGINAL OF THIS CONSENT SHALL BE KEPT IN YOUR MEDICAL RECORD AND A COPY PROVIDED TO YOU FOR YOUR RECORDS AND TO THE HOSPITAL IF THE PROCEDURES ARE PERFORMED IN A HOSPITAL. THIS CONSENT IS AN IMPORTANT DOCUMENT AND SHOULD BE RETAINED WITH OTHER VITAL RECORDS.

6. I consent to the performance of the procedures designated above as well as with the disposition arrangements set forth in this Consent and the attached Advanced Written Directive.

________	________	________________	________________	______
Date	Time	Signature (Intended Parent/Patient)	Print Name	Initials

________	________	________________	________________	______
Date	Time	Signature (Partner)	Print Name	Initials

If this document was interpreted:

Print:________________________________ or________________________________

VMI or in person interpreter name — 244 Tel. Interpreter ID Number Date Time

Language:_____________________________

_____ Telephone Consent Obtained by Practitioner

Second Witness to Telephone Consent:________________________________

Print Name of Second Witness to Consent: ________________________________

Informed Consent Attestation:

I have discussed the procedures above, including the risks, benefits, and alternatives with the patient and her partner. I have also explained that with any procedure there is always the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any procedure or treatment.

All questions were answered and the patient (and her partner, if applicable) consents to the procedures designated above.

________	________	________________	________________	______
Date	Time	Signature (Title of Practitioner)	Print Name	Pager #

AS REQUIRED UNDER CALIFORNIA STATE LAW, THE ORIGINAL OF THIS CONSENT SHALL BE KEPT IN YOUR MEDICAL RECORD AND A COPY PROVIDED TO YOU FOR YOUR RECORDS AND TO THE HOSPITAL IF THE PROCEDURES ARE PERFORMED IN A HOSPITAL. THIS CONSENT IS AN IMPORTANT DOCUMENT AND SHOULD BE RETAINED WITH OTHER VITAL RECORDS.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

ADVANCED WRITTEN DIRECTIVE REGARDING DISPOSITION OF EMBRYOS

This Advanced Written Directive sets forth options for disposition of the embryos that you received through your Donors that remain following your fertility treatment if certain unanticipated events occur (*i.e.,* death, divorce, separation or abandonment). California law requires that a health care provider delivering fertility treatment provide this form to individuals undergoing fertility treatment and to their partners.

Please initial only one item under each of the following numbers.

(1) In the event of the death of either partner, the embryos shall be disposed of by one of the following actions:

______ ______ Made available to the living partner.

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(2) In the event of the death of both partners or the death of a patient without a partner, the embryos shall be disposed of by one of the following actions:

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

ADVANCED WRITTEN DIRECTIVE REGARDING DISPOSITION OF EMBRYOS

This Advanced Written Directive sets forth options for disposition of the embryos that you received through your Donors that remain following your fertility treatment if certain unanticipated events occur (*i.e.,* death, divorce, separation or abandonment). California law requires that a health care provider delivering fertility treatment provide this form to individuals undergoing fertility treatment and to their partners.

Please initial only one item under each of the following numbers.

(1) In the event of the death of either partner, the embryos shall be disposed of by one of the following actions:

______ ______ Made available to the living partner.

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(2) In the event of the death of both partners or the death of a patient without a partner, the embryos shall be disposed of by one of the following actions:

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

ADVANCED WRITTEN DIRECTIVE REGARDING DISPOSITION OF EMBRYOS

This Advanced Written Directive sets forth options for disposition of the embryos that you received through your Donors that remain following your fertility treatment if certain unanticipated events occur (*i.e.,* death, divorce, separation or abandonment). California law requires that a health care provider delivering fertility treatment provide this form to individuals undergoing fertility treatment and to their partners.

Please initial only one item under each of the following numbers.

(1) In the event of the death of either partner, the embryos shall be disposed of by one of the following actions:

______ ______ Made available to the living partner.

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(2) In the event of the death of both partners or the death of a patient without a partner, the embryos shall be disposed of by one of the following actions:

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(3) In the event of separation or divorce of the partners, the embryos shall be disposed of by one of the following actions:

______ ______ Made available to the patient.

______ ______ Made available to the partner.

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(4) In the event of the partners' decision or a patient's decision who is without a partner, to abandon the embryos by request or a failure to pay storage fees, the embryos shall be disposed of by one of the following actions:

______ ______ Donation for quality assurance, quality improvement, education and training and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

(3) In the event of separation or divorce of the partners, the embryos shall be disposed of by one of the following actions:

______ ______ Made available to the patient.

______ ______ Made available to the partner.

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(4) In the event of the partners' decision or a patient's decision who is without a partner, to abandon the embryos by request or a failure to pay storage fees, the embryos shall be disposed of by one of the following actions:

______ ______ Donation for quality assurance, quality improvement, education and training and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(3) In the event of separation or divorce of the partners, the embryos shall be disposed of by one of the following actions:

______ ______ Made available to the patient.

______ ______ Made available to the partner.

______ ______ Donation for quality assurance, quality improvement, education and training, and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

(4) In the event of the partners' decision or a patient's decision who is without a partner, to abandon the embryos by request or a failure to pay storage fees, the embryos shall be disposed of by one of the following actions:

______ ______ Donation for quality assurance, quality improvement, education and training and/or research purposes.

______ ______ Thawed with no further action taken.

______ ______ Donation to another couple or individual.

______ ______ Return to Agency (if applicable).

______ ______ Other permitted disposition (please describe)

____.

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

This Advanced Written Directive represents the election of the undersigned in the scenarios described. This document shall be read in conjunction with the Consent Form: To Receive Donated Embryos and to Undergo Embryo Transfer also signed by the undersigned. In the event of a conflict between the two documents, this Advanced Written Directive shall control.

Date	Time	Signature (Intended Parent/Patient)	Print Name	Initials
Date	Time	Signature (Partner)	Print Name	Initials
Date	Time	Signature (Title of Practitioner)	Print Name	Pager #

This Advanced Written Directive represents the election of the undersigned in the scenarios described. This document shall be read in conjunction with the Consent Form: To Receive Donated Embryos and to Undergo Embryo Transfer also signed by the undersigned. In the event of a conflict between the two documents, this Advanced Written Directive shall control.

Date	Time	Signature (Intended Parent/Patient)	Print Name	Initials
Date	Time	Signature (Partner)	Print Name	Initials
Date	Time	Signature (Title of Practitioner)	Print Name	Pager #

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

This Advanced Written Directive represents the election of the undersigned in the scenarios described. This document shall be read in conjunction with the Consent Form: To Receive Donated Embryos and to Undergo Embryo Transfer also signed by the undersigned. In the event of a conflict between the two documents, this Advanced Written Directive shall control.

Date	Time	Signature (Intended Parent/Patient)	Print Name	Initials
Date	Time	Signature (Partner)	Print Name	Initials
Date	Time	Signature (Title of Practitioner)	Print Name	Pager #