Transport “Out” Consent

**These template documents were revised before the US Supreme Court decision in *Dobbs v. Jackson* (which repealed Roe v. Wade), and therefore, SART has not reviewed the template documents and did not make any changes based on the *Dobbs* decision. SART strongly recommends that before any SART template document is put into use in a Member's practice, the document should be reviewed by the Member's local legal counsel to ensure that the language conforms to current federal, state and local laws as these may have recently changed or are in the process of being changed.**

DESCRIPTION

This document informs the intended parents about the process and risks of transporting reproductive tissue (sperm, eggs, embryos) from one program to another.

TARGET

* All intended parents transferring reproductive tissue (sperm, eggs, embryos) from one clinic to another.

RELEASE NOTES

* This is the 1st version of this document
* Signature page allows for Witness as well as Notary verification.

TO DO

* Modify this document according to local needs and preferences.
* Get legal review to assure conformance with State and local laws and regulations

***DISCLAIMER.***

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The ‘Transport-Out’ of Frozen Reproductive Tissues

Process, Risk, Consent

**Intended Parent A: D**ate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Intended Parent B:** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(We) (I) request transport out of (our) (my): (Please check each box that applies)

**Frozen embryos:**

 *(Requires names and signatures of both intended parents)*

**🞏 Frozen partner sperm, epididymal and/or testicular tissue:**

 *(Requires male name and signature only; Partner name requested)*

**🞏 Frozen donor sperm:**

 *(Requires female recipient name and signature only)*

**🞏 Frozen oocytes (eggs):**

 *(Requires female name and signature only)*

that were frozen on or about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) to the possession and control of:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We (I) acknowledge this transport out consent requires the signature of intended parents who signed the original embryo freezing consent; of the male partner only for frozen sperm, epididymal and/or testicular tissue; and of the female intended parent only for frozen oocytes or frozen donor sperm. We (I) agree that if we (I) inherited these frozen samples for our (my) own use or obtained the frozen samples for use from a known donor, copies of these agreements and/or consents must be provided along with this consent. In that case, only the signature of the individual(s) involved in that agreement is (are) required.

Risks of Shipping and Transport:

The CLINIC and, as appropriate, its employees, contractors, consultants and authorized agents, agrees to provide its best efforts to pack the frozen samples in a container provided by the above-named recipient physician, program or facility. Packing will be performed consistent with written directions provided by that physician, program or facility. The CLINIC shall not be responsible for the safety and physical integrity of the frozen samples once the container is shipped and subsequently comes into the possession of the receiving intended parent, physician, program, facility, or any designated agent including commercial shipping companies or couriers.

We (I) are (am) aware that the transporting of frozen samples involves certain risks to that material, and if any of this material thaws during transport, it may be damaged or destroyed. We (I) understand that if our (my) samples were frozen by a method known as vitrification, that the samples are especially fragile.

We (I) agree to accept any and all costs and risks involved in the transporting of any frozen samples. We (I) hereby release the CLINIC, its employees, contractors, consultants and authorized agents, from any and all responsibility for the safety and integrity of the frozen samples, once it no longer is in the possession and control of the CLINIC. We (I) acknowledge that the CLINIC makes no guarantees as to the security or method of the packing or transfer method, to the safe thawing of the frozen samples, or to a successful pregnancy. We (I) understand that equipment failure, materials failure, natural disasters and human errors have occurred during the processing, shipping, and storage of frozen samples. We (I) understand and agree that the CLINIC shall be responsible only for acts of negligence on its part and the part of its employees, contractors, consultants and authorized agents. We (I) have carefully read this agreement and fully understand its contents. We (I) are (am) aware that this form is a release of liability, and we (I) sign it of our (my) own free will.

Confidentiality:

We (I) understand the confidentiality of medical records, including any photographs, X-rays or recordings, will be maintained in accordance with applicable state and federal laws. We (I) may request my records be released to other physicians.

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

We (I) acknowledge that we have read and understood the information provided above regarding the process of transferring gametes or embryos to a different facility and its risks and agree to go forward as our signatures below testify.

Intended Parent A Signature Date

Intended Parent A Name Date of Birth

Intended Parent B Signature Date

Intended Parent B Name Date of Birth

**Notary Public**

Sworn and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_.

X

Notary Signature Date

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*If signed in the office:*

**Statement by Witness (must be employee and at least 18 years old)**

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of their own free will. They signed this document in my presence.

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_