Recipients of Donor Embryos Info & 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**These template documents were revised before the US Supreme Court decision in *Dobbs v. Jackson* (which repealed Roe v. Wade), and therefore, SART has not reviewed the template documents and did not make any changes based on the *Dobbs* decision.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 Recipients about Donor Embryos therapy in detail, including the risks to the donors, recipient(s) (“Recipient”) and offspring. It then asks the Recipient to consent to this therapy with its risks.

TARGET

* All Recipients of Donor Embryos

RELEASE NOTES

* This is the second version of this document
* Risks to recipient and offspring updated based on current literature
* PGT language included
* Page 1 allows identification of the intended parent(s).
* Revised guidelines (2017) for maximum number of embryos to transfer included
* Wording shortened and simplified where possible
* Signature page allows for Witness as well as Notary verification.

TO DO

* Modify this document according to local needs and preferences.
* Replace “CLINIC” with your program’s name throughout.
* Get legal review to assure conformance with State and local laws and regulations.

***DISCLAIMER.***

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Recipients of Donor Embryos

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

Intended Parent #1 **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intended Parent #2 **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Donor Embryo therapy treats infertility due to egg and sperm problems, or due to certain genetic issues. The goal of Donor Embryo therapy is for you to become pregnant using embryos created from the eggs and sperm of other individuals. These embryos have been frozen and now donated for use by you. Embryos may be donated without disclosing the donor’s identify; or they may be donated openly, where both donors and recipients are known to each other.

You have decided to use donated embryos after considering other available treatments for infertility, and also considering the options of adoption or not having children. With donated embryos, there is no guarantee that pregnancy will occur or will continue to a live birth. If more than one embryo is transferred, there may be a multiple birth.

Recipients of donor embryos do not go through the egg stimulation and retrieval process. However, the risks of preparing the uterus to receive the embryo, and the embryo transfer procedure, are the same as for women who use their own eggs to achieve a pregnancy through IVF.

Steps in the Process

Your Screening

Recipients of donor embryos will have screening that includes taking a medical history, doing a physical exam, having psychological counseling, and undergoing blood tests and possibly urine tests. The woman who will carry the pregnancy will also have an evaluation of her uterus.

Screening of Embryo Donors

You will be informed of the medical, psychological, genetic and family history of the embryo donors, to the extent of the clinic’s knowledge. No screening or testing regimen is perfect, so it is possible for children with major congenital malformations (birth defects) or health problems to occur despite appropriate screening. All donors are also tested for infectious diseases including HIV (the virus responsible for AIDS), syphilis, and hepatitis (types B and C), although this testing may not have been done in a special FDA-approved lab. Even with this screening, it is possible that an infectious disease could be transmitted to a child conceived with the donated embryos or to the woman who will carry the pregnancy.

Embryo Transfer into Recipient or Carrier

* The number of embryos transferred affects the pregnancy rate and the risk for twins or other multiple pregnancies
* Embryos are placed in the uterus using a thin tube under ultrasound guidance

One or more embryos are placed in the uterus using a thin tube (catheter). Ultrasound may be used to help guide the catheter. It can also confirm placement through the cervix and into the uterus.

The number of embryos to transfer is an important decision. The age of the woman at the time of egg retrieval, and embryo quality affect, both the chance for pregnancy as well as the chance that multiple embryos could implant and result in a multiple pregnancy (twins, triplets, and more). In some cases, an embryo can split into two (identical twins) after transfer. Before the transfer, it is critical to discuss with your doctor how many embryos to transfer. If the donor was under age 35 and the best embryo looks normal, then in most cases only one embryo should be transferred.

Hormonal Support

* For pregnancy to occur, the embryo(s) must attach to the lining of the uterus. This process is called implantation.
* The lining depends on two hormones – estradiol and progesterone – to permit implantation and sustain pregnancy.
* Endometrial preparation can be achieved in natural, stimulated, or medicated cycles.

The important hormones to support implantation are progesterone and estrogen. Normally, the ovary makes enough of both hormones to support pregnancy.   However, in recipient cycles, achieving this synchrony requires active management. When a natural cycle is used, the embryo transfer occurs about a week after ovulation. In some cases, ovarian stimulation is chosen to induce follicle growth; in this case embryo transfer again occurs about a week after ovulation. Programmed cycles involve providing estradiol and progesterone on a fixed schedule to prepare the uterus for pregnancy. In medicated cycles, estrogen and progesterone are supplied. Estrogen is given by mouth, patch, or vaginal suppository. Progesterone is given by the intramuscular or vaginal route.  These hormones are usually continued for several weeks to support the pregnancy. There are advantages and disadvantages to each of these approaches to preparing the uterus. Considerations such as feasibility, ease, scheduling, and risk are weighed. There are certain differences in obstetric and neonatal outcomes to consider.

Additional Elements to Consider Regarding the Donated Embryos:

 Intracytoplasmic Sperm Injection (ICSI)

* In some cases, fertilization will not occur when eggs and sperm are placed together in a lab dish. Injecting a sperm into each egg (ICSI, or intracytoplasmic sperm injection) can help fertilization occur.
* ICSI does not guarantee normal fertilization.
* There may be an increased risk of genetic problems in children born from ICSI.
* ICSI will not improve any defects in the eggs.

ICSI involves the direct injection of a single sperm into the interior of an egg using an extremely thin glass needle. This lets the sperm enter the egg without having to break through the shell around the egg (the zona pellucida).

ICSI is a good choice when the sperm count, movement, or quality is poor. Live birth rates are very close to those of IVF for men with normal sperm counts.

However, ICSI may be associated with a slightly higher risk of birth defects. It is hard to know if the increased risk is due to the ICSI procedure itself or to defects already present in the sperm. The risk of birth defects after ICSI is still quite small (4.2% compared with 3% in children conceived naturally .

Children conceived by ICSI have slightly more problems with their sex chromosomes (the X and Y chromosomes) than children conceived by IVF alone, but only by a very small margin (0.8% to 1.0% for ICSI pregnancies compared to 0.2% for IVF pregnancies). The reason for the difference is not clear. It may be caused by the ICSI procedure itself, or by the chromosomes carried by the father. Men with sperm problems such as very low count and low motility are more likely to have genetic abnormalities.

 Preimplantation Genetic Testing (PGT)

* Preimplantation genetic testing of embryos currently requires removal of cells from the embryo (embryo biopsy).
* This test is most often done on Day 5 or Day 6 of embryo development, but it may be done sooner in some circumstances.
* The cells removed from the embryo may be sent to an off-site lab for the testing, while embryos remain in storage at the clinic.
* In most cases, the tested embryos will need to be frozen while the test is being run.
* Test results can be incorrect. Genetic testing does not guarantee the birth of a perfectly healthy baby.
* Some clinics automatically discard embryos identified as abnormal. This should be discussed with your clinic before the testing is done.

There are several reasons that some Intended Parents choose to do PGT. Current reasons include:

* determining whether the embryo has the correct number of chromosomes (so called “aneuploidy”) (“PGT-A”).
* determining whether the embryo has a structural rearrangement /translocation of its chromosomal material (“PGT-SR”).
* determining whether the embryo has a specific disease-causing mutation (“PGT-M”)
* determining the genetic sex of the embryo.

PGT does not guarantee that a pregnancy will occur, even if embryo testing is normal. Factors other than the genes or chromosomes also influence the chance for pregnancy.

Screening the embryo’s chromosomes, or testing for one specific genetic disease, does not guarantee that the embryo will be healthy and free of other disorders. For example, some common disorders that cannot be checked with PGT are autism and diabetes. Some birth defects can also occur even if chromosome screening is normal. An example of this would be a cleft lip or palate (failure of the lip and upper mouth to join properly).

Risks of embryo biopsy

* *Embryo damage.* There is a small risk of damage to the embryo. This may result in no pregnancy when one would have occurred if not for the biopsy procedure.
* *No result.* The test may not give a result in up to 5% of cases. Sometimes, there is not enough material retrieved to run the test. It may be possible to repeat the biopsy and try again to test the embryo.
* *Mixed results or diagnosis, such as mosaicism*. Test results can suggest that 2 different populations of cells exist in the embryo (normal cells and abnormal cells together). There is currently no evidence to determine which, if any, embryos designated as mosaic may have a chance to result in a successful, healthy pregnancy. Some clinics will not transfer mosaic embryos. This should be discussed with your clinic staff. Lower implantation rates and higher miscarriage rates have been reported with transfer of mosaic embryos; however apparently several healthy live births have also been reported.
* *Misdiagnosis.* The test may give the wrong result, and say that a normal embryo is actually abnormal, or that an abnormal embryo is actually normal. The accuracy of the testing is determined by the off-site lab. Most testing is very accurate, so the chance of a misdiagnosis is low. Furthermore, since not all embryos are made up of cells with identical genetics (“mosaicism”), it is possible that accurate test results do not reflect the genetics of the entire embryo. Consequently, the current recommendation is to confirm the result in early pregnancy.

*Note that depending on Clinic policy, embryo selection based on the sex of the embryo, and/or the transfer of genetically abnormal embryos, may not be permitted. Please review your Clinic’s policies.*

 Assisted Hatching

* Assisted hatching involves making a small hole in the outer shell (zona pellucida) that surrounds the embryo.
* Hatching may make it easier for embryos to be released from the shell and implant in the uterus.

The cells that make up the early embryo are enclosed by a shell called the zona pellucida.  Normally, as the embryo grows, this shell breaks open and releases the embryo. “Assisted hatching” makes it easier for the embryo to escape the shell. This is done in the embryology laboratory by making a small hole in the shell with a needle or a laser. Assisted hatching may have some risks, including more identical twinning and (rarely) damage to the embryo.

   Embryo Freezing

* Freezing of eggs or embryos provides an additional chance for pregnancy in the future.
* Freezing eggs and embryos do not always survive the process of freezing and thawing.
* Ethical and legal questions can arise when couples separate or divorce. It is vital to agree on what will be done with remaining eggs or embryos in those cases.

There are many reasons eggs and/or embryos may be frozen: they may be surplus, they may be undergoing genetic testing, the uterine environment for a fresh transfer is thought to be compromised, or the risk of ovarian hyperstimulation syndrome (OHSS) may be high. Some women may wish to freeze their eggs instead of embryos because they are not ready to conceive with their current partner, because they are planning to have therapy such as cancer treatment that could damage their eggs, or regardless of their current circumstances because they want to retain their reproductive autonomy. While freezing helps extend fertility, it is not without some risk and does not guarantee that the frozen eggs or embryo will be available for later use.

*Risks of freezing:*

Not all eggs or embryos will be successfully frozen.  The process of freezing, storage, and thawing can damage eggs or embryos.  This means that not all eggs or embryos may be available for further treatment.

There is a very small potential risk that gametes or embryos that are frozen may not be properly labeled or transferred to the individual(s) who stored them. This can arise from human error in fertilizing eggs or human or mechanical errors in labeling and storing eggs, sperm or embryos. While every SART clinic and embryology lab has protocols designed to avoid such errors through reasonable efforts to properly identify, label, store, thaw, and transfer reproductive tissue, errors in these steps are possible and patients understand and accept the risks inherent in such steps.

Studies of animals and humans indicate that children born from frozen embryo cycles do not have any greater chance of birth defects than children born after fresh embryo transfers.  However, until very large numbers of children have been born from frozen embryos, it is not possible to be absolutely certain that there are no increased risks.

*If you choose to freeze eggs or embryos, you MUST complete the Disposition of Embryos (or Eggs) Agreement before freezing. This statement may need to be notarized. The statement explains the choices you have for disposing of the eggs or embryos in a variety of situations that may arise. You can submit a new statement later if you change your mind about your choices. For frozen embryos, any change requires that both parties — you and your partner-- agree in writing to the change.*

Risks

Risks to Embryo Recipient

Getting pregnant through IVF comes with certain risks. This is partly because women using IVF are often older than those who might get pregnant on their own. In addition, the cause of the infertility itself may be to blame. There may be other risks linked to IVF that are not known at this time. Please see the table below for certain known risks.

Risks of Pregnancy with IVF

|  |  |  |
| --- | --- | --- |
|  | **Singleton Pregnancies** | **Twin Pregnancies** |
|  | Incidence in IVF Pregnancies (%) | Risk compared to other infertile women | Risk compared to fertile women | Incidence in IVF Pregnancies (%) | Risk compared to other infertile women | Risk compared to fertile women |
| Gestational diabetes | 8.2% | No difference | 41% higher | 10.7% | No difference | 23% higher |
| Pregnancy-induced hypertension | 12.6% | No difference | No difference | 25.5% | No difference | 15% higher |
| Placental complications | 5.2% | 95% higher | 281% higher | 4.9% | No difference | 83% higher |
| Primary cesarean delivery | 32.2% | 10% higher | 20% higher | 65.4% | 8% higher | 17% higher |
| Low birthweight (<5.5 pounds) | 7.7% | 21% higher | 65% higher | 50.4% | No difference | No difference |
| Preterm birth (<37 weeks gestation | 10.3% | 26% higher | 70% higher | 53.8% | No difference | 7% higher |

About 7% of IVF pregnancies are multiple pregnancies (twins, triplets, or greater) in 2019, of which less than 1% are triplets or more. Identical twins occur in less than 5% of all IVF pregnancies. Identical twins may happen more often after blastocyst (Day 5 or 6) transfers. Multiple pregnancies in general have an increased risk of pregnancy problems. In addition to early delivery, problems include pre-eclampsia (high blood pressure and protein in the urine), excess bleeding with delivery, and diabetes of pregnancy (gestational diabetes). Problems with the placenta (afterbirth) are also more common. Other problems more common with multiple pregnancy include gall bladder problems, skin problems, and the need for extra weight gain.

In IVF, embryos are transferred directly into the uterus. Still, tubal, cervical, or abdominal pregnancies can sometimes occur. These abnormal pregnancies may need to be treated with medication or surgery. Abnormal pregnancies within the uterus can also occur.

*Age-related risk to recipient / carrier*

Certain risks of pregnancy increase with age. Most common are high blood pressure, diabetes, bleeding while pregnant, and growth problems for the baby. Above 44 years of age, it is prudent to have a consultation and full medical evaluation before becoming pregnant. This may involve both an internist and a high-risk obstetrician.

Risks to Your Baby

* IVF babies may be at a slightly higher risk for birth defects and genetic defects.
* IVF has a greater chance of multiple pregnancy, even when only one embryo is transferred.
* A multiple pregnancy is the greatest risk to your baby when using IVF.

Overall Risks

The first IVF baby was born in 1978. Since then, more than 10 million children around the world have been born through IVF.  Studies have shown that these children are quite healthy overall.

Birth Defects

The risk of all birth defects through natural or spontaneous conception is about 3-5%. In IVF babies, the risk for any birth defect is about 5-6%. There may be, specifically, an increased risk of cardiac (heart) defects. Most of the increased risk with IVF seems to be due to the pre-existing infertility in couples using IVF and older maternal age.

There are a few other potential increased risks for babies born through IVF:

*Imprinting Disorders*. These are very rare disorders caused by certain genes from the mother or the father not being expressed. An example is Beckwith-Wiedemann Syndrome, which is more common in children conceived with IVF. These disorders are extremely rare (1 out of 15,000 people). Children from IVF treatment have a small increased risk of 0.01%.

*Childhood cancers*. There does not appear to be a higher risk of most cancers in children born from IVF, but there may be a higher risk of hepatic (liver) cancer. These are very rare in children.

*Infant development.* Most studies of long-term developmental outcomes for children have been reassuring so far. However, these studies are hard to do, and they have some limitations. There may be an increased risk of cerebral palsy however this risk is mostly from prematurity and low birth weight resulting from multiple pregnancy. Some studies show an increased risk of autism associated with ICSI, but others do not.

Risks of a Multiple Pregnancy

It is riskier for a baby to be a twin or triplet than a single pregnancy. Fortunately, fewer than one in ten IVF pregnancies are multiple, and that rate is declining due to lowering the number of embryos transferred into the uterus.

Early delivery accounts for most of the extra problems associated with babies from multiple pregnancies. IVF twins deliver an average of three weeks earlier than IVF single babies, and they weigh about 2 pounds less than IVF single babies.  Triplet (and greater) pregnancies deliver before 32 weeks (7 months) in almost half of cases. Early delivery can increase the risk of cerebral palsy, retinopathy of prematurity (eye problems that result from early delivery), and chronic lung disease. Multiple pregnancies also have increased risk of growth problems in the uterus, so the babies are born a low weight.

Multiple fetuses that share the same placenta, such as most identical twins, have additional risks, such as birth defects. Twin-to-twin transfusion syndrome, where the circulation is not equal between the fetuses, may occur in up to 20% of twins who share a placenta. This can increase the risk of fetal death.

Lastly, there is an increased risk of stillbirth with multiple pregnancies. The risk of stillbirth for a singleton pregnancy is 0.54%. The risk with twins is higher at 2.3% and with triplets 5.3%. The death of one or more fetuses in a multiple pregnancy (“vanishing twin”) can happen in the pregnancy and can happen in up to 36% % of twin pregnancies. This can affect the health of the surviving fetus.

Limits to the Success of the Process

There are a number of reasons IVF using donated embryos may be unsuccessful:

* The recipient’s lining may fail to develop adequately.
* The frozen embryo may not survive the thaw.
* The embryo transfer may be difficult or may not be possible.
* Implantation of the embryos into the wall of the uterus may not occur, even with the use of selective assisted hatching and/or genetic screening.

**Laboratory.** An event may occur in the laboratory resulting in loss or damage to some or all of the embryos. The CLINIC will take reasonable measures to maintain and monitor this equipment. However, despite their best efforts, equipment failure may result in the damage or loss of one or more of the embryos. 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, and consultants. The program will account honestly for all embryos.

Pregnancy Loss. Although pregnancy may be successfully established, there is still the possibility of miscarriage, ectopic pregnancy, stillbirth and/or congenital abnormalities (birth defects). Conceptions resulting from IVF/ET) have been associated with a slightly higher risk of birth defects than pregnancies resulting from a natural conception. However, it is still unclear whether the risk is related to intended parent(s), medications, or laboratory procedures. It is possible that infertile couples differ from the general population, and it is not the technology that leads to the higher risk.

*Psychosocial effects of infertility treatment*

Finding out that you or your partner is infertile or have a lower fertility can be very painful. Infertility and its treatment can affect your emotions, your health, your finances, and your social life. Treatment, particularly IVF, is time-consuming and may strain your personal relationships and your religious or ethical beliefs. During treatment, you may feel anxious, helpless, depressed, or all alone. You may go through highs and lows. In some cases, you may want to seek the help of a mental health expert to help you manage the stress. Your clinic can provide resources to professional in your area.

*Reporting Outcomes*

In 1992, the Fertility Clinic Success Rate and Certification Act was passed.  This law requires the Centers for Disease Control and Prevention (CDC) to gather information about IVF cycles and pregnancy outcomes in the U.S. each year.  This information is used to calculate success rates which are reported each year.

We (the Clinic) will report the required information from your IVF procedure to the CDC.  Since our Clinic is a member of the Society of Assisted Reproductive Technologies (SART) of the American Society for Reproductive Medicine (ASRM), it will also be reported to SART.  Information reported to SART about your cycle may be used for research or quality assessment according to HIPAA guidelines; your name will never be connected to your cycle information in any research that is published by ASRM or SART.

Special Issues with the Use of Donor Embryos

**Donor Identity.**

The identity of the embryo donor(s) can be known (“directed”) or unknown (“non-identified”). This is a joint decision of the donor(s) and recipient(s).

If our embryo donor(s) are not known to us, we agree that we will never seek to learn their identity, except as allowed for below or if a court orders otherwise. We (I) also understand that the CLINIC will not reveal our identities to the donor(s) except as allowed below, as required by law, or if a final non-appealable court order orders otherwise. However, we (I) understand that if a child born from this donation has a medical or psychological need that might be met by the donor(s), then we may contact the CLINIC and ask that our request be relayed to the donor. Such requests may be for a medical or psychological need. Furthermore, once any child or children born from this donation are legal adults, a request may also be made by the child or children for the identity of the donor(s) to be revealed. The donor(s) are under no obligation to consent to any request. We also understand the CLINIC may be unable to reach the donor(s) at any future date.

We understand that the offspring of any donation may request to learn of the identity of the donor(s) when they reach adulthood. The donor(s) are under no obligation to agree to this request but is also not prohibited from agreeing. Furthermore, it is possible that a court could compel disclosure of the donor(s)’ identity at any time.

Information on all cycles of Assisted Reproductive Technology treatment, along with data identifying recipients and women who undergo ART with their own eggs, is currently collected into a national database under federal law, the 1992 Fertility Clinic Success Rate and Certification Act. As part of this process, the Society for Assisted Reproductive Technology plans to begin to collect identifying information on all egg donors. As with recipient cycles and cycles for women using their own eggs, this information may be used to track outcomes.  For this purpose, certain donor identifying information such as name, date of birth, and social security number may be reported to a Registry by SART member clinics for data aggregation purposes. ASRM guidelines currently require permanent records be kept for all egg donation cycles. Efforts to collect this information are intended to respect donation confidentiality and not to disclose confidential identifying information to recipients, donors, or offspring. Control of such information in the future may, however, depend on applicable law.

Parental Rights and Responsibilities.

We (I) understand and accept our (my) responsibilities for the care of any child resulting from the embryo donation process, and it is our (my) intent to be the legal parent(s) of any child that results from the embryo donation process, with all the rights, responsibilities and obligations that come from a legal parent-child relationship. Under no circumstance will we (I) seek financial assistance from the donor(s) or the CLINIC. We (I) understand that neither the CLINIC nor the donor(s) will assume any financial responsibility for the upbringing of any child resulting from the embryo donation process under any circumstances. We (I) also assume responsibility for all costs associated with the use of donor embryos.

We (I) understand that that laws governing legal parentage of any child born through egg, sperm or embryo donation vary from state to state. Furthermore, such laws may apply to: children born or residing in a given state; parents [or donors? Legal folks, what do you think?] who reside in a given state; or the state where a CLINIC is located. In some states, embryo donation is legally recognized by statute; in others, parents may be able to obtain a pre-birth Court order establishing parental rights, in others, they may consider a formal adoption of the child (or children), and in others, there may be no option, requirement, or need to take additional steps to establish legal parentage. We understand and acknowledge that t**he CLINIC does not offer legal advice on these matters and are not relying on the CLINIC for such legal advice; and we (I) acknowledge that it is recommended we (I) consult an attorney with expertise in family law related to assisted reproductive technologies in the relevant/applicable state(s).**

Confidentiality.

We (I) understand and agree that, if we have a “directed” / known donor(s), aspects of our (my) medical care and conditions and that of the donor(s) may be revealed to, and/or discerned by, one another as part of the treatment process.

We (I), expect this procedure to be performed with not less than the customary standard of care. We (I) understand the risks and benefits as outlined above.

We (I) have had the opportunity to review this treatment and ask questions of our (my) physician concerning the alternative options to utilization of donated eggs, including adoption and no treatment. The full egg donation process has been explained to us (me), together with the known risks. We (I) understand the explanation that has been given to us. We (I) have had the opportunity to ask any questions we (I) might have and those questions have been answered to our (my) satisfaction. Any further questions may be addressed to the CLINIC staff or Dr. John Smith at (123) 456-7890. We (I) acknowledge that utilization of donated eggs is being performed at our (my) request and with our (my) consent.

We (I), the undersigned, request, authorize and consent to the use of donated embryos by the CLINIC, and as appropriate, its employees, contractors, and consultants and authorized agents for the purpose of achieving a pregnancy.

X

Intended Parent A Signature Date

Intended Parent A Name Date of Birth

**Notary Public**

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

Notary Signature Date

----------------------------------------------------------------------------------------------------------------

X

Intended Parent B Signature Date

Intended Parent B Name Date of Birth

**Notary Public**

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

Notary Signature Date

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**Statement by Witness (must be employee of Clinic and at least 18 years of age)**

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

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

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

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