

Female Patient Name: _____ Social Security # _____

Male Patient Name: _____ Social Security # _____



**THE CENTER FOR HUMAN REPRODUCTION (CHR)—ILLINOIS/NEW YORK CITY*
RECIPIENT CONSENT TO THE USE OF DONATED EMBRYOS THROUGH
EMBRYO ADOPTION (DONATION)**

Description, Explanation and Informed Consent

We, _____, and _____, hereby authorize the professional representation of the Center for Human Reproduction (CHR) to transfer embryos, donated by an anonymous couple, into the uterus of the female partner.

We have been informed that the couple who donated the embryos was screened for infectious diseases prior to the donation of the embryos but that such screening does not completely eliminate the risk of infectious disease transmission. We have also been informed that these embryos have been cryopreserved (frozen) and that there is a risk that one (1), more, or all of the embryos may not survive the thaw.

We understand that we will be receiving these embryos through CHR's **Embryo Adoption Program**. We also understand that the total number of embryos that we will receive will be determined by the physicians and embryologists of CHR. This determination will be done following the CHR's Embryo Adoption Program Protocol.

We hereby agree to rely on the expertise and discretion of CHR's physicians and embryologists in the selection of qualified embryo donors. We also acknowledge and agree that the identity of the couple who donated their embryos to us will NOT be revealed to us under any circumstances.

We have been advised that the selected embryo(s) will be transferred in routine fashion to the uterus of the female partner using an embryo transfer catheter. We have also been informed and understand:

1. That transfer of one or more embryos may not result in recipient's pregnancy;
2. That, if a recipient pregnancy does result from embryo transfer, the pregnancy may not reach full term;
3. That any pregnancy of the recipient may result in complications during childbirth;
4. That any child, born as a result of such a pregnancy, may be abnormal or that a child may be born with undesirable hereditary tendencies; and
5. That there may be other adverse consequences to the recipient or the embryos and/or her offspring.

We have been given the opportunity to ask questions about the procedures, the methods being used and the risks and hazards involved and we believe that we have sufficient information to give this informed consent. We have also discussed with a physician alternative treatments and it is our independent decision to accept the risks described above.

We hereby agree that any child, born as a result of our participation in the Embryo Adoption Program, is a child conceived by our acts and hereby acknowledged that such child is our legitimate child with all the rights and privileges accompanying such status.

We understand that there are no charges and/or costs for the embryos we receive. We, however, have been informed and understand that administrative fees are non-refundable. We understand that these said fees are to include, but may not be limited to, a (\$500.00) Embryo Matching Fee, a (\$683.00) fee to thaw the embryos and all open embryo storage fees. We also understand that all fees are to be paid prior to the beginning of the Frozen Embryo Transfer Cycle and are subject to change without prior notice.

We have received a written description of CHR's Assisted Reproductive Technology Program and understand the financial responsibility for our involvement in the program as a recipient couple. We also understand that, by entering this program, we are financially responsible for all the costs incurred by ourselves.

* Per NY State Law doing business as the Medical Offices for Human Reproduction (MOHR)

All of our questions regarding the Center for Human Reproduction Recipient Consent To The Use Of Donated Embryos Through Embryo Adoption (Donation) have been answered. Each of us has read the consent and acknowledges receipt of a copy of this consent.

Date Signature of Female Patient Female Name – Print

Date Signature of Partner Partner Name – Print

As one of the members of The Center for Human Reproduction, by my signature indicate that the foregoing consent was read, discussed and signed in my presence.

Date Signature of Witness (Female Patient) Witness Name – Print

Date Signature of Witness (Partner) Witness Name – Print

NOTE: If you or your partner are unable to have this consent witnessed by a staff member at CHR or FULLY UNDERSTAND THE CONSENT, please notify the CHR medical staff. We will provide you with further information and a witness. If you wish to sign the consent outside of CHR, please have the consent notarized.

State of _____, County of _____ ss., I, the undersigned, a Notary Public in and for the said County in the

State aforesaid; DO HEREBY CERTIFY that _____
(Female Patient / Partner)

personally known to me as the same persons whose names are subscribed to the foregoing document appeared before me this day in persons, and acknowledged that he and she signed, sealed and delivered the said document as his and her free and voluntary act, for the use and purposes therein set forth.

Given under my hand and official seal this _____ day of _____, 20_____.

Commission expires on: _____, 20_____.

(Notary Public)

(Notary Seal)