

**CONNECTICUT FERTILITY ASSOCIATES
SPERM DONATION/EMBRYO TRANSFER
CONSENT BY GENETIC FATHER
(Gestational Carrier Arrangement)**

Intended Parent Name: _____ **SS#:** _____ - _____ - _____

Intended Parent Name: _____ **SS#:** _____ - _____ - _____

I, the undersigned, request, authorize and consent for gestational surrogacy at Connecticut Fertility Associates, and, as appropriate, its employees, contractors, and consultants and authorized agents.

My partner and I have entered into a gestational carrier arrangement under which a Gestational Carrier will be implanted with our embryos.

1. Sperm Collection and Fertilization

I understand and agree that I will provide a sperm specimen. My sperm will be treated and prepared to optimize fertilization. The physicians will then combine my sperm with harvested eggs to allow fertilization to occur.

After several cell divisions and after it is deemed that an embryo or embryos are developing normally, an embryo or embryos will be transferred into the Gestational Carrier's (surrogate) uterus. I hereby consent and allow Connecticut Fertility Associates to implant my genetic material into the uterus of the

Gestational Carrier Name: _____

2. Embryo Transfer to the Gestational Carrier

Although not risks to me personally, I understand the following may occur, which may prevent the formation of embryos and the establishment of pregnancy in the Gestational Carrier:

- a) The egg retrieval may be canceled for medical indications and therefore no egg harvest performed.
- b) An attempted egg retrieval may be unsuccessful (no eggs retrieved).
- c) The egg or eggs may not be normal even if retrieved.
- d) I may be unable to produce a semen specimen.
- e) Fertilization of the eggs may not occur and no embryos therefore produced.
- f) Cleavage or cell division of the fertilized egg(s) may not occur and the embryos arrest in development.
- g) The embryo(s) may not develop normally.
- h) Implantation of the embryos into the uterus of the Gestational Carrier may not occur.

I also understand there is no guarantee the embryo transfer procedure will result in pregnancy in the Gestational Carrier.

Within the normal human population, a certain percentage (approximately 3-4%) of children are born with physical or mental illness and that the occurrence of such illness is beyond the control of physicians. Connecticut Fertility Associates and their physicians do not assume responsibility for the physical and/or mental characteristics of any child or children born as a result of embryo transfer to the Gestational Carrier. I understand that within the normal population, approximately 10-20% of pregnancies result in miscarriages and that this may occur after in vitro fertilization and embryo transfer. Similarly, obstetrical complications may occur in any pregnancy. I also understand and accept that the procedure carries with it a small risk of sexually transmitted diseases being transmitted to the Gestational Carrier and/or child or children, including but not limited to hepatitis and Human Immunodeficiency Virus (HIV)

During pregnancy and delivery, the same types of complications may arise as with a child conceived through sexual intercourse. It is possible that pregnancy could result in the birth of a child or children with undesirable traits or hereditary tendencies, or possess any other problems or disabilities of children conceived by sexual intercourse. I understand and agree to care for the child or children regardless of any possible problems.

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The Gestational Carrier will be tested for syphilis, hepatitis and HIV. I will also undergo these tests. I understand that if a screen is positive, I will not be a candidate for the procedures. Appropriate medical referral will be made.

3. Separate Legal Agreement

We have consulted with a lawyer to address the many legal concerns arising from the gestational surrogacy arrangement involving the transfer of our embryo(s) into the Gestational Carrier. I understand that the Gestational Carrier has certain personal rights regarding her body, including the right to undergo a fetal reduction or abortion procedure, to terminate the pregnancy.

This informed consent, therefore, is not a contract to cure, a warranty of treatment, or a guarantee of conception. I absolve, release, and hold harmless Connecticut Fertility Associates, its associated physicians, and affiliates, from any and all liability for the mental or physical nature or character of any child or children conceived or born under the procedures described in this document, for legal liability regarding the gestational surrogacy arrangement, and for affirmative acts or acts of omission which may arise during the performance of the procedures described here.

* * *

I have been assured that all information obtained will be handled confidentially and neither my identity nor specific medical details will be revealed by my physicians without my consent. Specific medical details may be revealed in professional publications as long as my identity is concealed.

I agree that Connecticut Fertility Associates will furnish emergency medical care determined to be necessary by the medical staff. I agree to be responsible for the cost of the care described here, either personally or through medical insurance or other form of medical coverage. I also agree to cover the costs associated with the in-vitro fertilization and embryo transfer procedure to the Gestational Carrier, either personally or through medical coverage. Finally, I understand that no monetary compensation for wages lost as a result of injury will be paid to me by Connecticut Fertility Associates.

I have read this consent form and have had all of my questions and concerns adequately answered. We (I) may receive a copy of this consent form. We (I) have been encouraged to ask questions until they have been answered to my satisfaction. Any further questions can be addressed to Any further questions can be addressed to Connecticut Fertility Associates or to its Medical Director, Dr. Michael B. Doyle, at 203-373-1200, or 203-855-1200.

_____ Signature of Sperm Donor/ Genetic Father/Husband	_____ Date	_____ Signature of Witness	_____ Date
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_____ Signature of Partner	_____ Date	_____ Signature of Witness	_____ Date
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This consent has been read by and discussed with the patient and her partner, where applicable.

_____ Signature of CFA Physician	_____ Date
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