CONNECTICUT FERTILITY ASSOCIATES
CONSENT FOR THAW OF CRYOPRESERVED EMBRYO(S)
AND EMBRYO TRANSFER

Intended Parent Name: ______________________________**SS#**:___________ - __________ - __________

Intended Parent Name: ______________________________**SS#**:__________ - __________- __________

We (I), the undersigned, request, authorize and consent to the **thawing and utilization of cryopreserved (frozen) embryos** stored by Connecticut Fertility Associates and as appropriate, its employees, contractors, and consultants and authorized agents for us.

We (I) understand that there is no guarantee that any of the embryos will survive the thawing process. Furthermore, we (I) understand also that there is no guarantee that the transfer of the thawed embryos will result in a conception. We (I) understand and consent that the number of embryos thawed is at the discretion of the Connecticut Fertility Associates staff in consultation with us (me). Furthermore, the number of embryos thawed will be determined by the embryo quality and number at freezing and thawing, the age of female, the medical conditions leading to our (my) infertility and our (my) choice in consultation with our (my) physician. We (I) also understand and agree that the Connecticut Fertility Associates staff may perform selective assisted hatching on these embryos, if needed.

We (I) understand that, just as was the case with our (my) initial cycle of IVF using fresh embryos, the transfer of more than one embryo into the uterus of the gestational carrier may result in a multiple pregnancy. We (I) understand that multiple pregnancy is associated with an increased risk of miscarriage and premature birth. In the case of a premature birth, the resulting children may not survive or if they do survive, they may experience significant long-term health problems associated with their premature delivery.

We (I) understand that the process of utilizing the frozen/thawed embryos may require for the gestational carrier the use of hormones and monitoring using ultrasound and blood tests to determine the optimal time to perform the embryo transfer and to support the function of the uterine lining after transfer. The process also involves an embryo transfer as described in the IVF Consent that we have previously signed.

Thawing and Utilization of Cryopreserved Embryos 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 we (I) might have may be addressed to the Connecticut Fertility Associates staff or to its Medical Director, Dr. Michael B. Doyle at 2O3-373-1200, or 203-855-1200, or 2203-799-1200.

We (I) acknowledge that thawing and utilization of cryopreserved embryos is being performed at our (my) request and is purely voluntary. We (I) understand that we (I) may withdraw my consent at any time and that my present or future care will not in any way be affected by my decision.

We agree with the plan that embryos will be thawed until the agreed upon planned number of embryos for transfer has been reached. We understand that it may require that all cryopreserved embryos in storage be thawed in order to reach this number (i.e., the embryologists will continue to thaw embryos until the planned number of embryos for transfer has been achieved).

Number of Cryopreserved Embryos in Storage:	
Planned Number of Embryos for Transfer:	

We (I) acknowledge that this consent must he signed by the same individual(s) who executed the original cryopreservation consent. We (I) understand, agree and acknowledge that we (I) are (am) not married to individuals who are not parties to this informed consent.

__________________________ ____________ __________________________ ________________
Signature of Patient Date Signature of Witness Date

__________________________ ____________ __________________________ ________________
Signature of Partner Date Signature of Witness Date

Note: Each Signature Must Be Witnessed Separately

This consent has been read by and discussed with the patient and partner, where applicable.

____ ________________
Signature of Physician Date