Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT TO DONATE EMBRYOS/GAMETES TO AN INDIVIDUAL OR COUPLE

NOTE: THIS WRITTEN CONSENT IS AN IMPORTANT DOCUMENT AND THE COPY PROVIDED TO YOU SHOULD BE RETAINED WITH OTHER VITAL RECORDS FOR FUTURE REFERENCE.

SPECIAL CONSIDERATIONS

The possibilities of third party donations and the existence of cryopreservation (freezing) have raised a set of new legal and ethical issues for which there are few guidelines. The nature of the cryopreserved human embryo/gamete, its legal status, and the status of a child resulting from the donation of an embryo/gamete to a friend, relative or stranger are all questions to which there are currently few definitive answers. The psychological and emotional ramifications of donation are also unknown. Nevertheless, embryo/gamete donation is a service that is technically possible and desired by both donors and recipients.

Please complete the applicable line.

I, ______________________________, ("Donor, single"), or

I, ______________________________, and I, ______________________________,("Donors, couple");
the undersigned, are each at least eighteen (18) years of age.

I/We am/are participating voluntarily in the Lucile Salter Packard Children's Hospital at Stanford ("LPCH") in vitro fertilization (IVF) program and wish to donate an embryo(s) or gamete(s) to (i) women/couples who are unable to produce eggs of their own to be fertilized and reimplanted, (ii) women/couples whose eggs, even if fertilized and reimplanted, are unlikely to lead to a normal pregnancy, or (iii) women/couples who, for any other reason, have chosen embryo/gamete adoption as a means to have a child (referred to herein as "Recipient(s)").

I/We understand that prior to embryo/gamete donation, comprehensive genetic and medical information will be obtained from me/us, from my/our medical records, from physical examinations and otherwise, to determine whether I/we am/are suitable candidate(s) for embryo/gamete donation. I/We may have already had blood tests during the IVF process for Rh factor incompatibility and infectious and sexually transmitted diseases, including, but not necessarily limited to, HIV (the virus that causes AIDS), agents of viral hepatitis (HBV and HCV), human T lymphotropic virus-1 (HTLV-1), and syphilis. Because I/we understand that there is no conclusive test for detecting HIV infection, I/we also hereby certify that I/we have not, to my/our best knowledge, contracted HIV, engaged in unprotected sexual activity with someone with HIV/AIDS or who has used intravenous drugs illegally or otherwise under non-sterile conditions, or otherwise has engaged in behaviors that have put them at specific risk for infection with HIV. In addition, I/we have undergone a psychological evaluation by a counselor. I/We hereby certify that the genetic and medical history information that I/we have provided in connection with the donation of embryos is complete and accurate to the best of my/our knowledge.

I/We acknowledge that we have been informed by a LPCH physician with timely, relevant, and appropriate information regarding the options LPCH will have for disposition of excess human embryos or gametes not used during the Recipient's (as defined below) fertility treatments. I/We understand that any unused embryos or gametes that remain after the Recipient's fertility treatment may be (i) donated by LPCH to another individual or couple, (ii) stored by LPCH, (iii) discarded by LPCH in accordance with LPCH policy, (iv) donated by LPCH for purposes related to quality assurance and quality improvement and/or education and training, or (v) donated by LPCH for purposes related to research, which may include genetic testing.

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Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT TO DONATE EMBRYOS/GAMETES TO AN INDIVIDUAL OR COUPLE

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I, ______________________________, and I, ______________________________,("Donors, couple");
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Stanford MEDICINE

Fertility and Reproductive Health

CONSENT TO DONATION OF EMBRYOS/GAMETES

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

1. I/WE HEREBY CONSENT TO DONATE THE NUMBER OF OUR EMBRYO(S) OR GAMETE(S) SPECIFIED IN SECTION 11 TO:

Please Initial:

Donor (single) | Donor (partner, if couple)

________ ________ ____

or

________ ________ An unknown individual/couple or unknown individuals/couples with infertility or genetic disease participating in a LPCH program.

I/We also consent to LPCH's practice that any embryo(s) or gamete(s) donated to the above individual/couple (the "Recipient"), which are not used in such individual/couple's infertility treatment, may be (i) discarded in accordance with LPCH's policies, as in effect from time to time, (ii) stored by LPCH, (iii) used or donated by LPCH for purposes related to quality assurance and quality improvement and/or education and training, (iv) used or donated by LPCH for research purposes, which may include genetic testing, or (iv) donated to another couple for infertility treatment purposes.

I/We also understand that LPCH reserves the right to terminate its embryo or gamete cryostorage program at any time. In the event of such termination and to the extent my/our donated embryos or gametes have not yet been donated to a Recipient, LPCH will provide at least three (3) months prior notice to allow me/us to identify another facility willing to accept the frozen embryos or gametes for storage. In the event that arrangements for transfer of the embryos or gametes to another facility are not made during such notice period, and in the absence of other contrary written instructions from me/ us, I/we hereby authorize LPCH to transfer any embryos or gametes of mine/ours to another facility or to take any other actions with respect to the embryos permitted under applicable law.

2. CONFIDENTIALITY OF IDENTITY OF RECIPIENT (THIS SECTION IS APPLICABLE TO ANONYMOUS DONATIONS ONLY)

Please initial:

Donor (single) | Donor (partner, if couple)

________ ________ I/We understand that the identity of the Recipient (unless already known) Will not be disclosed to me/us, nor will my/our identity be revealed to the Recipient (unless already known). I/We understand, however, that LPCH will disclose such information if required to do so by Court order, or if failure to do so would subject LPCH to liability for contempt.

________ ________ I/We understand that no entry will be made in my/our personal medical records as to the disposition of any donated embryo(s)and, other than my/our Donor number, no entry will be made in the personal medical record of the Recipient as to the source of the donated embryo(s) or gamete(s).

1. I/WE HEREBY CONSENT TO DONATE THE NUMBER OF OUR EMBRYO(S) OR GAMETE(S) SPECIFIED IN SECTION 11 TO:

Please Initial:

Donor (single) | Donor (partner, if couple)

________ ________ ____

or

________ ________ An unknown individual/couple or unknown individuals/couples with infertility or genetic disease participating in a LPCH program.

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Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

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Please Initial:

Donor (single)	Donor (partner, if couple)	
________	________	______________________________
		or
________	________	An unknown individual/couple or unknown individuals/couples with infertility or genetic disease participating in a LPCH program.

I/We also consent to LPCH's practice that any embryo(s) or gamete(s) donated to the above individual/couple (the "Recipient"), which are not used in such individual/couple's infertility treatment, may be (i) discarded in accordance with LPCH's policies, as in effect from time to time, (ii) stored by LPCH, (iii) used or donated by LPCH for purposes related to quality assurance and quality improvement and/or education and training, (iv) used or donated by LPCH for research purposes, which may include genetic testing, or (iv) donated to another couple for infertility treatment purposes.

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2. CONFIDENTIALITY OF IDENTITY OF RECIPIENT (THIS SECTION IS APPLICABLE TO ANONYMOUS DONATIONS ONLY)

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________	________	I/We understand that no entry will be made in my/our personal medical records as to the disposition of any donated embryo(s)and, other than my/our Donor number, no entry will be made in the personal medical record of the Recipient as to the source of the donated embryo(s) or gamete(s).

________ ________ I//We understand that it may be necessary for my/our physician to keep certain records as part of the hospital record concerning the source and disposition of donated embryo(s)/gamete(s). I/We agree that medical details related to the embryo/gamete donation may be revealed in professional publications, as long as my/our anonymity is preserved.

3. CONTINUING OBLIGATIONS

Please initial:

Donor (single)	Donor (partner, if couple)	
________	________	I//We promise to notify LPCH of any changes in my/our address.
________	________	I/We hereby give my/our permission to LPCH to provide all medical information that is part of my/our LPCH questionnaire to the "Recipient(s)" or any offspring that may result from these donated embryo(s) or gamete(s). This information will be supplied to the Recipient without providing any personal identifiers that could reasonably be expected to link the medical information back to my/our identity.
________	________	I/We understand that LPCH, in keeping with federal regulations, sends data (and agrees to permit these data to be verified by audit) to the federal Centers for Disease Control and Prevention ("CDC") national registry which is maintained by the Society for Assisted Reproductive Technology, an affiliate of the American Society for Reproductive Medicine. The 1992 Fertility Clinic Success Rate and Certification Act requires that the CDC collect data on all assisted reproductive technology cycles performed in the United State annually and report success rates using these data. LPCH may provide my/our identifying information, including but not limited to name(s) or social security number(s) to the CDC in connection with such required reporting. Because sensitive information will be collected by the CDC, the CDC has obtained an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). It is also possible that at some time in the future, information regarding the treatment of a particular Recipient with a donated embryo/gamete including but not limited to health and other information that identifies you could be part of a governmental audit of LPCH by other governmental entities such as the United States Department of Health and Human Services, the California Department of Public Health or the California Health and Human Services Agency. Any such audit may include, but not be limited to, examination of medical and laboratory records and comparison of the data in the medical records with the data in governmental reporting databases.

________ ________ I//We understand that it may be necessary for my/our physician to keep certain records as part of the hospital record concerning the source and disposition of donated embryo(s)/ gamete(s). I/We agree that medical details related to the embryo/gamete donation may be revealed in professional publications, as long as my/our anonymity is preserved.

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Please initial:

Donor (single) | Donor (partner, if couple)

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4. RISKS OF DONATION

Please initial:

Donor (single)	Donor (partner, if couple)	
_______	_______	I/We have been fully advised that the psychological and emotional risks to The Donor(s), and/or the Donor(s)'s Partner and family, of voluntary donation of embryos/gametes are currently unknown.

5. RELINQUISHMENT OF ALL RIGHTS TO THE EMBRYO(S)/GAMETE(S) AND TO RESULTING OFFSPRING

It has been explained to me/us that the legal rights and obligations of the parties involved, including the rights of the embryo(s)/gamete(s) and any fetus(es) and/or child(ren) born as the result of the transfer to the Recipient's uterus of the donated embryo(s) are not free from doubt. We have also had the opportunity to consult with independent legal counsel of my/our own choice, a physician, and psychologist/counselor. I/we hereby relinquish all legal rights to the donated embryos/gametes now and forever as set forth below:

Please initial:

Donor (single)	Donor (partner, if couple)	
_______	_______	*If the intended Recipient of the donated embryo(s)/gamete(s) is a known or unknown woman/couple participating in an LPCH program who is not the Donor's Partner:* I/We have considered all of the information provided to us, from various sources, and knowingly relinquish all rights of any kind both now and in the future to the embryo(s)/gamete(s), including but not limited to the relinquishment of all rights with respect to any resulting fetus(es) and/or child(ren) and any future uses of such embryo(s)/gamete(s) for other purposes as outlined in this Consent.
_______	_______	*If the intended Recipient of the donated embryo(s)/gamete(s) is the Donor's Partner:* We have considered all of the information provided to us, from various sources, and we hereby state our express agreement and intent that the Donor and her/his Partner agree and intend to jointly hold all rights to the donated embryo(s)/gamete(s) and any resulting fetus(es) and/or children) both now and in the future. We further consent to disposition by LPCH of any excess embryos/gametes consistent with the possible future uses outlined in this Consent.

6. AUTHORITY TO DONATE EMBRYO(S)

Please initial:

Donor (single)	Donor (partner, if couple)	
_______	_______	I/We certify that if my/our donated embryo(s) were created using the genetic material of donated egg(s) or sperm, I/we have no existing agreements with the donor(s) of such genetic material or any other parties (such as a sperm bank) regarding my/our ability to use or donate or regarding our rights with respect to the resulting embryo(s).

4. RISKS OF DONATION

Please initial:

Donor (single) | Donor (partner, if couple)

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Please initial:

Donor (single) | Donor (partner, if couple)

_______ _______ *If the intended Recipient of the donated embryo(s)/gamete(s) is a known or unknown woman/couple participating in an LPCH program who is not the Donor's Partner:* I/We have considered all of the information provided to us, from various sources, and knowingly relinquish all rights of any kind both now and in the future to the embryo(s)/gamete(s), including but not limited to the relinquishment of all rights with respect to any resulting fetus(es) and/or child(ren) and any future uses of such embryo(s)/gamete(s) for other purposes as outlined in this Consent.

_______ _______ *If the intended Recipient of the donated embryo(s)/gamete(s) is the Donor's Partner:* We have considered all of the information provided to us, from various sources, and we hereby state our express agreement and intent that the Donor and her/his Partner agree and intend to jointly hold all rights to the donated embryo(s)/gamete(s) and any resulting fetus(es) and/or children) both now and in the future. We further consent to disposition by LPCH of any excess embryos/gametes consistent with the possible future uses outlined in this Consent.

6. AUTHORITY TO DONATE EMBRYO(S)

Please initial:

Donor (single) | Donor (partner, if couple)

_______ _______ I/We certify that if my/our donated embryo(s) were created using the genetic material of donated egg(s) or sperm, I/we have no existing agreements with the donor(s) of such genetic material or any other parties (such as a sperm bank) regarding my/our ability to use or donate or regarding our rights with respect to the resulting embryo(s).

4. RISKS OF DONATION

Please initial:

Donor (single)	Donor (partner, if couple)	
_______	_______	I/We have been fully advised that the psychological and emotional risks to The Donor(s), and/or the Donor(s)'s Partner and family, of voluntary donation of embryos/gametes are currently unknown.

5. RELINQUISHMENT OF ALL RIGHTS TO THE EMBRYO(S)/GAMETE(S) AND TO RESULTING OFFSPRING

It has been explained to me/us that the legal rights and obligations of the parties involved, including the rights of the embryo(s)/gamete(s) and any fetus(es) and/or child(ren) born as the result of the transfer to the Recipient's uterus of the donated embryo(s) are not free from doubt. We have also had the opportunity to consult with independent legal counsel of my/our own choice, a physician, and psychologist/counselor. I/we hereby relinquish all legal rights to the donated embryos/gametes now and forever as set forth below:

Please initial:

Donor (single)	Donor (partner, if couple)	
_______	_______	*If the intended Recipient of the donated embryo(s)/gamete(s) is a known or unknown woman/couple participating in an LPCH program who is not the Donor's Partner:* I/We have considered all of the information provided to us, from various sources, and knowingly relinquish all rights of any kind both now and in the future to the embryo(s)/gamete(s), including but not limited to the relinquishment of all rights with respect to any resulting fetus(es) and/or child(ren) and any future uses of such embryo(s)/gamete(s) for other purposes as outlined in this Consent.
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Please initial:

Donor (single)	Donor (partner, if couple)	
_______	_______	I/We certify that if my/our donated embryo(s) were created using the genetic material of donated egg(s) or sperm, I/we have no existing agreements with the donor(s) of such genetic material or any other parties (such as a sperm bank) regarding my/our ability to use or donate or regarding our rights with respect to the resulting embryo(s).

_______ _______ I/We certify that I/we have sole and exclusive authority to donate my/our embryo(s) regardless of the source of the genetic material used to create such embryo(s). I/we also certify that we are not aware of any claims by any third-parties for harm or losses with respect to my/our donated embryos.

7. STIPEND OR COMPENSATION

Please initial:

Donor (single) Donor (partner, if couple)

_______ _______ I/We understand that LPCH will not provide any stipend or compensation to me/us for any time, inconvenience or other efforts required by me/us in connection with my/our embryo donation. I/we also understand that LPCH or Stanford University may share donated embryos/gametes for compensation with other parties for research purposes, and I/we understand that LPCH and Stanford University have no plans to compensate me for such sharing.

8. LEGAL STATUS

Please initial:

Donor (single) Donor (partner, if couple)

_______ _______ I/We understand that the legal status of embryos/gametes following donation is as yet uncertain and that there may be future changes in the law, including, without limitation, with respect to anonymity. I/We have had the opportunity to seek independent legal counsel of my/our own choice, and I/We nonetheless elect to proceed with donation despite possible changes to the law that may affect me/us in the future.

9. RELEASE OF LIABILITY

Please initial:

Donor (single) Donor (partner, if couple)

_______ _______ I/We hereby release LPCH, Stanford University, and the physicians, employees and agents thereof (collectively, "Stanford") from any and all claims and/or liability arising out of or in any way connected with our voluntary participation in the embryo/gamete donation program, except to the extent of any negligence or willful misconduct on the part of Stanford.

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10. WISHES CONCERNING FUTURE CONTACT

Please initial:

Donor (single) | Donor (partner, if couple)

________ ________ I/We consent to be contacted by LPCH in the event that a child who results from an embryo/gamete that I/we have donated requires the donation of tissue, bone marrow or an organ for which I/we am/are a possible donor match. I/We understand that consent to such contact does not obligate me/us to reveal my/our identity (to the extent I/We am/are anonymous donors), to be tested to determine whether I/we am/are such a match, nor to donate any such tissue, marrow or organ.

________ ________ I/We do not consent to be contacted by LPCH in the event that a child who results from an embryo/gamete that I/we have donated requires the donation of tissue, bone marrow or an organ.

* If not initialed above marked, LPCH shall not contact Donor(s) under these circumstances.

11. MY/OUR SIGNATURES BELOW INDICATE THAT I/WE HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I/WE HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS HAVE BEEN ANSWERED TO MY/OUR SATISFACTION. I/WE UNDERSTAND THAT I/WE MAY WITHDRAW FROM THE PROGRAM AT ANY TIME WITHOUT IT AFFECTING MY/OUR FUTURE THERAPY OR CLINICAL CARE AT LPCH, OR STANFORD UNIVERSITY AND THAT THERE WILL BE NO PENALTY FOR SUCH WITHDRAWAL. HOWEVER, SUCH WITHDRAWAL SHALL ONLY BE EFFECTIVE TO THE EXTENT LPCH HAS NOT ALREADY TAKEN ACTION IN RELIANCE UPON THIS CONSENT TO DONATE EMBRYOS/GAMETES TO AN INDIVIDUAL OR COUPLE.

Please complete the applicable line.

I, ______________________________, [name of Donor, single]; or

I, ______________________________, and I, ______________________________ [names of Donors, if couple];

do hereby donate _________________________ [number, if applicable, or "all"] of my/our embryos/gametes

to LPCH on behalf of ____ [a Recipient(s)

who is unknown to me, or name of Recipient(s) if known] for ______________________________

[specify purpose].

AS REQUIRED UNDER CALIFORNIA STATE LAW. THE ORIGINAL OF THIS CONSENT SHALL BE KEPT IN YOUR MEDICAL RECORD AND A COPY PROVIDED TO YOU FOR YOUR RECORDS AND TO THE HOSPITAL IF THE PROCEDURE TO REMOVE THE OVA IS PERFORMED IN A HOSPITAL. THIS CONSENT IS AN IMPORTANT DOCUMENT AND **SHOULD BE RETAINED WITH OTHER** VITAL RECORDS.

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Stanford MEDICINE

Fertility and Reproductive Health

CONSENT TO DONATION OF EMBRYOS/GAMETES

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

Date	Time	Signature, Donor	Print Name	Initials
Date	Time	Signature, Partner	Print Name	Initials
Date	Time	Signature, Witness (SFRMC)	Print Name	

Picture ID confirmed by:

Date	Time	Signature	Print Name

The above mentioned individual/couple has been informed and counseled by me and by others regarding the risks and benefits of embryo/gamete donation. The individual/couple appeared capable of understanding the information presented as demonstrated by our discussion and the responsive nature of the participation of the individual/couple.

DATE	TIME	Physician Signature:		
		PRINT Name:	Credentials	Pager Number, if applicable

DATE	TIME	Psychologist/Counselor Signature:		
		PRINT Name:	Credentials	Pager Number, if applicable

Date	Time	Signature, Donor	Print Name	Initials
Date	Time	Signature, Partner	Print Name	Initials
Date	Time	Signature, Witness (SFRMC)	Print Name	

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Stanford MEDICINE

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