Medical Record Number

Patient Name

CONSENT • INSEMINATION WITH DONOR SPERM

Addressograph or Label - Patient Name, Medical Record Number

I/We, _____("Recipient" and, if applicable, "Recipient's Partner"), the undersigned are each over eighteen (18) years of age.

I/We authorize Dr. _____("Physician") and her/his assistants at Lucile Salter Packard Children's Hospital at Stanford ("LPCH") to perform one or more inseminations on Recipient with sperm obtained from a donor(s) for the purpose of making Recipient pregnant.

I/We understand and agree that the sperm for the insemination procedure will be obtained from the _____ ("Bank"), located in _____, and will be frozen for storage purposes.

I/We have chosen this Bank from among several about which Physician and LPCH have given me/us information. Based on the donor information provided by the Bank, I/we have selected one or more donor(s) (the "Donor(s)").

The insemination with donor sperm procedure, including a description of the screening process for donors, and the risks inherent in that process and the procedure, have been explained to me/us by the Physician, and through the informational material from the Bank. I/We have had an opportunity to discuss the insemination with donor sperm procedure with Physician. I/We also have had an opportunity to discuss alternatives to the insemination with donor sperm procedure, including nontreatment and adoption.

I/We understand that the psychological and/or physical characteristics of any child(ren) resulting from sperm donation may not match those of the Recipient, the Recipient's Partner, if applicable, or those of the Donor. Unknown or undesirable genetic characteristics of the Donor and/or the Recipient might be expressed in a child resulting from insemination with donor sperm. I/We also understand that any child resulting from insemination with donor sperm has the usual risks of developmental, psychological and physical disabilities and/or illness like any child conceived other than through insemination with donor sperm. With full knowledge of the above, I/we hereby state my/our express agreement and intent that I/we shall conclusively be presumed to be the sole legal parent(s) of any fetus(es) and/or child(ren) resulting from the insemination. As the legal parent(s), I/we hereby agree to assume all parental, custodial and testamentary rights and obligations with respect to such fetus(es) and/or child(ren). I/We acknowledge that I/we have had an opportunity to consult independently with legal counsel.

1. Risks Associated with Insemination with Donor Sperm and Pregnancy.

   a. Failure of the Insemination to Result in Pregnancy. The success of the insemination cannot be guaranteed. I/We understand that development of pregnancy is dependent on factors some of which cannot be tested or predicted in advance, and no guarantees of pregnancy rates can be given.

   b. Risk of Infection. I/We understand that the Bank has screened the Donor(s) for HIV/AIDS and other medical conditions. I/We also understand that LPCH has not screened the Donor(s) or sperm. I/We understand that despite such screening it is possible to acquire an infectious disease, including HIV(the virus that causes AIDS), from the insemination with donor sperm procedure.

c. Complications of Pregnancy. If pregnancy results, there are risks of miscarriage, genetic defects, birth defects, stillbirths, and multiple births. There are many medical risks to both the pregnant woman and the baby(ies) associated with pregnancy itself whether conceived through intercourse or through the insemination procedure. Pregnancy complications, which may include, without limitation, high blood pressure, diabetes, liver disease, hemorrhage or seizures, may lead to serious permanent damage to the mother or death.

d. Abnormalities and Birth Defects. So far, there is no evidence that insemination with donor sperm causes an increased chance of abnormalities in the baby(ies). The risk of birth defects may or may not be higher than the usual risk of birth defects (2 to 5%) when conception occurs following intercourse.

e. Psychological Risks. The psychological and emotional risks of voluntary participation in an insemination program with donor sperm to the Recipient and/or her partner and family are currently not known.

f. Legal Status. I/We understand that there may be future changes in the law related to insemination with donor sperm, including, without limitation, with respect to anonymity. I/We have had an opportunity to seek independent legal counsel. (Applicable only if form is completed by Recipient and Recipient's Partner) We understand that according to California law, if a woman is inseminated with the consent of her husband, the husband is treated in law as if he were the natural father of any child thereby conceived. We understand that if we are not legally married to each other, however, legal status of Recipient's Partner as a parent of any child resulting from insemination is as yet uncertain.

2. Release of Liability. I/We hereby release LPCH, Stanford University, Physician and the employees and agents thereof (collectively, "Stanford") from claims and/or liability arising out of or in any way connected with my/our voluntary participation in the insemination program, except to the extent of any negligence or willful misconduct on the part of Stanford.

3. Financial Responsibility. I/We understand that I/we are solely financially responsible for the costs of all services and items provided by LPCH as part of the insemination procedures. I/We understand that I/we are also solely financially responsible for any costs related to any medical complications which the Recipient may experience. I/We have received LPCH's Schedule of Fees and have had the opportunity to meet with a financial counselor.

   I/We understand that LPCH is not responsible for any costs related to the insemination procedures or any related medical complications, should they occur. I (Recipient) certify that I have the following medical insurance, which will cover any medical complications I experience:

   _____

   Name of Carrier, Policy No. and Group Name

4. Marital Status. (check one)
   a. I (Recipient) hereby certify that I am
      - ☐ unmarried
      - ☐ married to the named Partner, if any, in this consent form
      - ☐ married to someone other than the named Partner

   b. I (Partner) (if applicable) hereby certify that I am (check one)
      - ☐ unmarried
      - ☐ married to Recipient
      - ☐ married to someone other than the Recipient

I/We understand there is no connection between the Bank and LPCH.

MY/OUR SIGNATURE(S) BELOW INDICATE THAT I/WE HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT I/WE CONSENT TO THE PERFORMANCE OF INSEMINATION WITH DONOR SPERM. 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 CAN WITHDRAW FROM THE PROGRAM AT ANY TIME WITHOUT IT AFFECTING MY/OUR FUTURE THERAPY OR CLINICAL CARE AND THAT THERE WILL BE NO PENALTY FOR SUCH WITHDRAWAL.

_____ _____ _____
Signature of Recipient Date Time

_____ _____ _____
Signature of Recipient's Partner (if applicable) Date Time

I hereby certify that I have discussed the insemination procedure and its risks and benefits with the Recipient and the Recipient's Partner named above.

_____ _____ _____
Signature of Physician Date Time

I hereby certify that_____
(Name of Recipient)

and, if applicable,_____,
(Name of Recipient's Partner)

who has/have presented documentation to me showing her/them to be the individual(s) named herein, appeared before me and signed the above consent to insemination.

Attached to this form is a photocopy of the informational material from the Bank which was provided to the Recipient and, if applicable, Recipient's Partner, who has initialed it.

_____ _____ _____
Signature of Witness (LPCH) Date Time

This consent is valid for one year or until the birth of a live child, whichever occurs sooner.