Lucile Salter Packard Children's Hospital

Stanford MEDICINE

Fertility and Reproductive Health

CONSENT • RECORD DOCUMENTATION ACKNOWLEDGEMENT / PRIMARY PATIENT WITH DONOR OR SURROGATE

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

Patient name:_____

Donor or Surrogate name:_____

I _____(patient) understand that as part of and as necessary for the infertility and reproductive care and treatment process, donor or surrogate information such as semen analysis result(s), oocytes retrieval and implantation, and other medical information relating to the infertility and reproductive care and treatment process will be recorded in my patient chart.

I understand that this information will become part of a permanent medical record which Lucile Salter Packard Children's Hospital at Stanford ("LPCH") is legally required to retain. I will not hold LPCH or its affiliates liable for continuing to maintain this record even in the event of termination of any form of relationship with the above named donor or surrogate.

I understand that if the record is requested and released pursuant to my request or as permitted or required by law, that information recorded in my record about the donor or surrogate may be disclosed as a result of the release of my record, and that I will not hold LPCH or its affiliates liable for disclosures of donor or surrogate information that was recorded in my chart as necessary for treatment.

I hereby give full consent to have the above referenced donor or surrogate's medical information relating to infertility and reproductive services included in my permanent medical chart.

I _____(donor or surrogate) understand and consent to the above and hereby give full consent to have my test results, analyses, and medical information relating to infertility and reproductive services included in the above referenced patient's permanent medical chart, and I will not hold LPCH or its affiliates liable for disclosures of my information that was recorded in the above referenced patient's chart for purposes of the infertility and reproductive care and treatment process.

Patient signature	Print Name	Date	Time
Donor or Surrogate signature	Print Name	Date	Time

Witness:_____
(Print Name and Title)

Signature	Date	Time

Witness:_____
(Print Name and Title)

Signature	Date	Time

(Please note: Acknowledgements signed outside LPCH require notarization before return.)