CONSENT FOR CRYOPRESERVATION AND STORAGE OF EMBRYOS

We (I), the undersigned, request, authorize and consent to the cryopreservation (freezing) and/or storage of embryos by Sanford Clinic North, doing business as Sanford Reproductive Medicine (Sanford) and, as appropriate, its employees, contractors, and consultants and authorized agents.

If numerous eggs are retrieved during our (my) cycle, all mature eggs will be exposed to sperm in order to develop as many embryos as possible. Any viable embryos not transferred to the uterus will be frozen (cryopreserved). We (I) understand that execution of this consent does not guarantee that embryos will be cryopreserved and the number of embryos frozen will be at the discretion of Sanford Reproductive Medicine (Sanford) staff, based upon the embryo quality and our (my) choice in consultation with our (my) physician. We (I) understand that we (I) will be notified if embryos are cryopreserved.

If a pregnancy does not occur as a result of the initial embryo transfer, if we (I) have a miscarriage, or if a successful pregnancy does not occur but we (I) subsequently desire another child, the frozen embryos will be available to us (me) for thawing and transfer during a subsequent menstrual cycle. This procedure may be repeated until all the frozen embryos have been utilized. We (I) understand and agree that it is a policy of Sanford Reproductive Medicine (Sanford) to store our (my) embryos for a maximum time period of one (1) year one (1) year one (1) year one (1) year one (1) year...

They will then be sent to a long term storage facility.

On average, only 60% of embryos survive the freezing and thawing process, so the number of embryos that are viable after thawing may be less than the number of embryos frozen. It is possible that none of the embryos will survive the freezing and thawing process. There is no guarantee that the transfer of frozen embryos will result in a successful pregnancy. We (I) have discussed Sanford Reproductive Medicine (Sanford)'s pregnancy rates for frozen embryo transfers with our (my) doctor. We (I) also understand that it does not appear that the utilization of frozen embryos increases our (my) risk of having a child with a birth defect above the incidence observed in the spontaneously conceiving population. We (I) understand that both the cryopreservation and storage procedures involve the use of mechanical and/or electrical equipment. Sanford Reproductive Medicine (Sanford) will make all best efforts to maintain and monitor this equipment and provide backup in the event of an equipment failure. However, despite their best efforts, equipment failure may result in the damage or loss of one or more embryos. We (I) understand and agree that Sanford Reproductive Medicine (Sanford) shall be responsible only for acts of negligence on its part and the part of its employees, contractors, and consultants and authorized agents if equipment failure occurs.

At any time during the storage of our (my) embryos, when our (my) treatment at Sanford Reproductive Medicine (Sanford) is completed, at the end of 1 (one) year of storage or if Sanford Reproductive Medicine (Sanford) closes (whichever comes first) we (I) understand that we (I) have two options regarding our (my) frozen embryos in storage at Sanford Reproductive Medicine (Sanford) including: a) Transfer of the cryopreserved embryos from the Laboratory at Sanford Reproductive Medicine (Sanford) to another Reproductive Center or b) long term storage facility.
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We (I) understand that each of these options requires execution of a separate written consent form signed by both of us (me) at the time that this option is exercised.

In the event of Death:

4. We (I) understand, agree and consent that if one of us dies (Please initial and check)
   - □ The disposition of the embryos will be left to the surviving partner.
   Female’s Initials_______________
   Partner’s Initials_______________

5. We (I) understand, agree and consent that if both of us die or if I die, (and I am a single woman) (PLEASE CHECK ONE AND BOTH PARTNERS SHOULD INITIAL):
   - □ The embryos will be transported to a long term storage facility at the expense of our (my) estate.
   - □ The disposition of the embryos will be left to the following designee (Same sex partners, please also write in designee):

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

   (Write in designee name, address and phone number)

   Female’s Initials_______________
   Partner’s Initials_______________

In the event that we divorce or our relationship ends:
We (I) understand, agree and consent that if we divorce or our relationship ends (PLEASE CHECK ONE AND BOTH PARTNERS SHOULD INITIAL):

- □ The disposition of the embryos will be left to the female partner.
- □ The disposition of the embryos will be left to the male partner.
- □ The disposition of the embryos is provided for by a divorce decree or legally binding document. Sanford would comply with the directives on that document upon receipt of a copy.
- □ The disposition of the embryos will be left to the following designee (Same sex partners, please write in designee):

   __________________________________________
   __________________________________________
   __________________________________________

   (Write in designee name, address and phone number)
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Female’s Initials_________________
Partner’s Initials_________________

Additional Considerations:
We (I) understand and agree that Sanford Reproductive Medicine (Sanford) will store these embryos for no longer than one year, regardless of any instructions indicated above.

We (I) understand and agree that, in any situation where there is a conflict between the parties, the embryos will be moved to a long term storage facility at our (my) expense.

We (I) understand and agree that it is our (my) obligation to keep Sanford Reproductive Medicine (Sanford) informed of our (my) current address. We (I) understand and agree that Sanford Reproductive Medicine (Sanford) is not liable for any destruction of embryos considered abandoned.

We (I) agree and acknowledge that we (I) are (am) not married to individuals who are not parties to this informed consent.

Storage:
We (I) will be billed, in advance, for storage of the embryos.

We (I) acknowledge that, at any time during the year storage period, we (I) can execute the appropriate consents to exercise the option of transferring to another facility or long term storage facility. We (I) understand that consent or transfer must be signed by both individuals who signed this Cryopreservation Consent, unless one of us dies, or I am a single woman, or an applicable court decree supersedes this requirement.

We (I) understand and agree that data from our (my) ART (Assistive Reproductive Technologies) procedure will also be provided to the Centers for Disease Control and Prevention (CDC). The 1992 Fertility Clinic Success Rate and Certification Act requires that CDC collect data on all ART cycles performed in the United States annually and report success rates using these data. Because sensitive information will be collected on us (me), CDC applied for and received an “assurance of confidentiality” for this project under the provisions of the Public Health Service Act, Section 308(d). This means that any information that CDC has that identifies us (me) will not be disclosed to anyone else without our (my) consent.
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We (I) understand and agree that pregnancy and birth of a child or children may result from our (my) participation in treatment and services at Sanford Reproductive Medicine (Sanford). We (I) understand and agree that Sanford cannot advise us (me) about the legal relationships or obligations that will result from a pregnancy or birth from participation in these services. We (I) understand and agree that we (I) should consult with an attorney of our (my) own choice to determine our (my) legal right and obligations regarding any pregnancy or birth resulting from participation in these services. We (I) release, indemnify, and hold harmless Sanford, its employees, contractors, consultants, and authorized agents from any and all liability, costs, expenses and attorneys’ fees regarding our (my) legal rights and obligation regarding a pregnancy or birth which occurs from participation in this program. We (I) voluntarily consent to participation in these services and to the legal rights and obligations that result.

We (I) understand that compliance with recommendations of the Sanford Reproductive Medicine (Sanford) is necessary to optimize the chances for successful treatment. We (I) agree to comply with those requirements. We (I) also understand that some tests, studies or procedures which are part of this treatment must be performed at Sanford Reproductive Medicine or another qualified Reproductive Medicine. Those requirements have been discussed with us (me) and we (I) agree to follow them. We (I) understand and agree that if we (I) do not follow recommendations of Sanford or comply with requirements for treatment, Sanford may elect to discontinue our (my) participation in treatment or services at Sanford Reproductive Medicine. If our (my) participation is discontinued for this reason, we (I) agree that Sanford will have no liability or further obligation to us (me).

Embryo cryopreservation and storage has been explained to us (me) by our (my) doctor, together with the known risks. We (I) understand the explanation that has been given to us (me). We (I) have had the opportunity to ask questions and those questions have been answered to our (my) satisfaction. Any further questions we (I) might have may be addressed to Sanford Reproductive Medicine (Sanford) staff or Dr. Steffen Christensen, Program Director. We (I) acknowledge that In Vitro Fertilization and Embryo Transfer (IVF/ET) and embryo cryopreservation is being performed at our (my) request and with our (my) consent.

_______/_______/__________ ___________________________________ ________________________
Date Female Signature Witnessed By

_______/_______/__________ ___________________________________ ________________________
Date Partner Signature Witnessed By

Physician Signature:
This consent has been discussed with the patient.

_______/_______/__________ ____________________________
Date Physician Signature