Mount Sinai Fertility
Sinai Health System

Mount Sinai Fertility
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CONSENT FOR RELEASE AND USE OF FROZEN EGGS, OVARIAN TISSUE, SPERM OR TESTICULAR TISSUE

Form # MSF – 111 (Oct 2016)

I, the undersigned, hereby consent to my involvement in the thaw and use for assisted reproductive treatments of my:

☐ Eggs ☐ Donor Eggs _____
Donor Name or ID

☐ Sperm ☐ Donor Sperm _____
Donor Name or ID

☐ Ovarian Tissue ☐ Testicular Tissue

I acknowledge that the nature, purpose and contemplated effects of the treatments and procedures have been fully explained to my satisfaction by the clinical staff of Mount Sinai Fertility, Mount Sinai Hospital. This consent form will be **valid for 60 days** from the date of signing.

If my partner, _____, presents unaccompanied at the time that the procedure is actually performed, I acknowledge that I am aware of the use of my frozen sperm, eggs or tissue for the procedure.

I understand that:

a) While the purpose of these procedures is to establish a viable pregnancy, I understand that there is no guarantee of success.
b) Eggs and sperm which have been frozen may not survive or may not fertilize.
c) I am free to withdraw from the treatments or procedures at any stage.

I have read and understand this agreement, accept its terms, and sign it voluntarily.

This consent is valid for 60 days from the date of signing and applies to one thaw procedure.

Date Signed (YYYY-MM-DD): _____

_____ ✍ _____ ✍
Patient Signature Witness Signature

_____ _____
Patient Printed Name Witness Printed Name