

CONSENT FORM FOR EGG DONATION AND GESTATIONAL SURROGACY

INSTRUCTIONS:

This consent form provides a description of the treatment that you are undertaking.

- Read the consent completely. If you have any questions please speak with your doctor.
- Do not make any additions or deletions to the consent.
- Treatment **cannot** be started until all consents are signed.
- Consents must be signed in front of your nurse or physician.

INTRODUCTION

Pregnancy can be achieved with egg donation and the use of a gestational surrogate. Two different women function as the egg donor and gestational surrogate. This treatment involves in vitro fertilization (IVF) and includes four main steps: 1) the development of eggs in the egg donor's ovaries; 2) the removal of eggs from her ovaries; 3) the placement of the eggs and sperm together in the laboratory to allow fertilization to occur, and; 4) the transfer of fertilized eggs (embryos) into the gestational surrogate's uterus for the establishment of pregnancy. The intention following the delivery is to unite the baby (or babies) with the intended parent(s).

This consent explains the treatment and describes the major risks. In addition, the responsibilities of those who participate in this treatment are discussed. This consent is valid for a period of one calendar year after it has been signed. Please make a copy for your records. It is recommended that you review the consent prior to each treatment cycle. If you have any questions about your treatment then it is your responsibility to speak with your physician.

DESCRIPTION OF THE TREATMENT

Egg donation/Gestational surrogacy treatment is done in conjunction with IVF and involves several steps. Success cannot be guaranteed at any or all of these steps. If optimal results are not appreciated at any step, it may be recommended that treatment be stopped and the cycle cancelled.

- I. **Ovulation Induction:** The egg donor will take medications to stimulate the development of multiple ovarian follicles (the fluid-filled cysts in the ovary that contain the eggs).
- II. **Egg Retrieval:** The egg donor will have the eggs removed from her ovaries.
- III. **Insemination of the Eggs:** The eggs and sperm will be placed together in the laboratory and incubated in an effort

to achieve possible fertilization and growth of the embryos.

- IV. **Preparation of the Endometrium:** The uterine cavity of the gestational surrogate will be hormonally prepared prior to the embryo transfer to allow implantation to occur.
- V. **Embryo Transfer:** One or more embryos will be transferred into the uterus of the gestational surrogate.
- VI. **Embryo Freezing:** Following the embryo transfer, any remaining embryos of suitable quality may be frozen (cryopreserved) and stored for future embryo transfer(s).

I. Ovulation Induction

The eggs are present in the ovaries within fluid-filled cysts called follicles. During a woman's menstrual cycle, usually one mature follicle develops, which results in the ovulation of a single egg. Several hormones including follicle stimulating hormone (FSH) and luteinizing hormone (LH) influence the growth of the ovarian follicle. These hormones are produced by the pituitary gland, which is located at the base of the brain. FSH is the main hormone that stimulates the growth of the follicle, which produces an estrogen hormone called *estradiol*. When the follicle is mature, a large amount of LH is released by the pituitary gland. This surge of LH helps to mature the egg and leads to ovulation 36-40 hours after its initiation.

The success of the treatment is dependent on the number of eggs that are removed from the ovaries. Medications are administered to increase the number of follicles that develop, which will increase the number of eggs that are obtained at the egg retrieval, which will increase the number of embryos that will be available for transfer. By increasing the number of embryos that can be transferred, the chance of pregnancy increases. There are several injectable medications that are used for this phase of treatment.

II. Egg Retrieval

The egg retrieval is an outpatient procedure performed at the Surgery Center of Waltham. In most cases, the procedure is accomplished under vaginal ultrasound guidance with the use of anesthesia. For this procedure, the woman is placed in the same position as if she was having a pelvic exam. After the anesthesia is given, the vagina is cleaned with a saline solution. The vaginal ultrasound probe is then placed in the vagina allowing visualization of the follicles within the ovaries. Under ultrasound guidance, a needle is passed through the vaginal wall and into the ovarian follicles. Fluid is aspirated from the follicles and then examined by a biologist to determine if eggs are present. During the egg retrieval, follicles from both ovaries are aspirated. The procedure is usually completed within twenty minutes. The complication rate following an egg retrieval is less than 1-2%. Complications may include pelvic infection, bladder infection, injury to the intestines and injury to blood vessels. Any of these complications and others could require a hospitalization and, possibly, additional medical and/or surgical treatment that could impair or prevent the chances of achieving pregnancy in the future. In rare instances, it may be necessary to remove one or both ovaries or perform a hysterectomy. An antibiotic is administered prior to the performance of the egg retrieval to reduce the chances of an infection. A side effect of this medication could be an allergic reaction.

III. Insemination of the Eggs

On the day of the egg retrieval, a sperm sample is obtained. Under some circumstances, sperm can be frozen prior to the day of egg retrieval for use on the day of egg retrieval. Reasons to consider sperm freezing would be if the male partner

may not be available on the day of the egg retrieval or there has been difficulty in the past with the production of a semen sample. You are responsible for making arrangements to freeze sperm prior to the start of treatment if this applies to you. The source of the sperm can be from the male partner or in some situations a sperm donor can be used. The biologist processes the sperm sample and then the eggs are inseminated. There are two approaches to the insemination of the eggs that are discussed below:

1. *Standard Insemination*- If the sperm sample is adequate then a standard insemination of the eggs can be performed. After the sperm sample has been processed, a mixture of the sperm and eggs is placed in a plastic dish containing a nutrient culture media and then placed in an incubator in the laboratory to allow fertilization to occur. The nutrient culture media contains a serum additive, which is a blood product, and there is a rare chance of transmission of a viral infection. The morning after the egg retrieval, the eggs are examined to see if fertilization has occurred.
2. *Intracytoplasmic sperm injection (ICSI)* - ICSI is a laboratory procedure performed to increase the chances of fertilization. The ICSI procedure is a process, whereby, with the aid of a microscope and fine instruments, a single sperm is injected directly into the egg. Indications for ICSI include- a previous IVF cycle with poor fertilization, a previous semen analysis demonstrating significant abnormalities and in situations where surgical aspiration of sperm from the vas deferens or testicle is required. In most cases it is known at the start of the IVF cycle that ICSI will be performed. However, in other cases the sperm sample on the day of the egg retrieval may be unexpectedly inadequate for standard insemination and the ICSI procedure may be performed.

The ICSI procedure- On the day of the egg retrieval, a sperm sample will be obtained and the most active sperm are isolated. An enzymatic solution will be added to the dishes with the eggs to loosen and separate the granulosa cells that surround the egg. This will allow visualization of the egg to determine its maturity. Only mature eggs can be treated with the ICSI procedure. With the aid of a microscope and fine instruments a single sperm is picked up and then injected into an egg. After the eggs undergo ICSI they are treated as described above under the heading of standard insemination.

The following risks are associated with the performance of the ICSI procedure:

1. The eggs may fail to become fertilized or may be damaged precluding their ability to be fertilized.
2. ICSI may yield presently unknown risks to the baby and/or mother.
3. Studies have shown that some cases of male infertility may be genetic. Therefore there is the possibility that infertility may be passed on to the offspring. Some studies show an increased risk of chromosomal and other abnormalities in babies born as a result of the ICSI procedure. If pregnancy is achieved testing can be performed to determine the chromosomal makeup of the fetus. If you would like additional information concerning genetics and inheritance, you should ask your physician to refer you to a genetic counselor prior to the start of your treatment cycle.
4. ICSI may compromise the protective effect of the membrane that surrounds the embryo, which may result in bacterial contamination and infection in the embryo that would render it non-viable.

On average, 60-70% of eggs will fertilize following the standard insemination or the ICSI procedure but in some cases none of the eggs fertilize. If fertilization is confirmed, plans are then made for the embryo transfer. In some cases of documented fertilization the embryos stop their development and the embryo transfer is cancelled.

IV. Preparation of the Endometrium

The gestational surrogate is administered hormones, including estrogen and progesterone, to prepare the endometrium for implantation.

V. Embryo Transfer

After fertilization has been confirmed, the development of the embryos is monitored in the laboratory. If the embryos continue their development then plans are made for the embryo transfer. The embryo transfer is performed 3 to 6 days following the egg retrieval. Embryos transferred 3 days after the egg retrieval are generally at the 4 to 8 cell stage. Embryos transferred on day 5 or 6 are at a more advanced stage and may have developed into a blastocyst, which is made up of over 50 cells. Your physician will discuss with you the optimal time of the transfer. In the event that the embryos stop their development an embryo transfer is not performed.

At the time of the embryo transfer, a physician will review the fertilization results and the development of the embryos. A decision will be made regarding the number of embryos that will be transferred. Increasing the number of embryos transferred will increase the chances of pregnancy, but will also increase the risk of a multiple pregnancy (e.g., twins, triplets, etc). Remaining embryos that are not transferred will be examined and, if they are of suitable quality, may be frozen, stored and transferred at a later date. Alternatively, these "extra" embryos can be discarded.

Embryos which result from abnormal fertilization (i.e., polyspermy -when more than one sperm fertilizes an egg) will be discarded because they have no chance of developing normally. In addition, embryos which fail to develop properly (e.g., fail to divide, demonstrate other significant abnormalities of development) will also be discarded. Eggs and/or embryos, which have failed to develop (not viable), will not be transferred and will be discarded.

In order to perform the embryo transfer the gestational surrogate is placed in the same position as if she were having a pelvic exam. A speculum is placed into the vagina and the cervix is visualized. The vagina and cervix are rinsed with a solution. The biologist loads the embryos into a catheter, which the physician inserts through the cervical canal and into the uterine cavity. Frequently, the physician will use an abdominal ultrasound to guide the catheter into the uterine cavity. After placement of the catheter the embryos are injected into the uterine cavity. The catheter is examined by the biologist to confirm that the embryos have been discharged. Following the procedure the gestational surrogate will be sent home. Activity should be limited on the day of the embryo transfer. Thereafter, normal activity should be resumed.

Following the embryo transfer the gestational surrogate will continue taking estrogen and progesterone until the 10th week of pregnancy. Progesterone and estrogen supplements are not FDA-approved for IVF treatment. It should be noted, however, that studies have shown that there is no increased risk of congenital anomalies or health risks to women who take natural estrogen and progesterone supplements during pregnancy.

Eleven days after embryo transfer, a blood pregnancy test will be done. If this test is found to be positive, a repeat pregnancy test may be done 2-3 days later. If the pregnancy test results are within expected values then a vaginal ultrasound will be done approximately five weeks after the embryo transfer to determine the status of the pregnancy.

VI. Embryo Cryopreservation of viable, high quality embryos (if any) not transferred:

I/We understand that to date, there are no known effects from long-term storage of cryopreserved (frozen) embryos. Although there are theoretical risks of congenital malformations, I/we understand that the best available research suggests that the rate of birth defects in children born following the cryopreservation of embryos is the same as the rate observed in an age-matched group of pregnant women who conceived without assisted reproduction:

1. _____ Patient initials _____ Partner initials I/We AGREE to embryo cryopreservation
(if applicable)

OR

2. _____ Patient initials _____ Partner initials I/We DO NOT AGREE to embryo cryopreservation
(if applicable)

Disposition of Cryopreserved Embryos:

Any disposition of embryos requires the written authorization of both partners. If your embryos were formed using eggs/sperm from a third party donor, your instructions to donate these embryos must be in accordance with prior agreements with the egg/sperm donor or applicable law. Your instructions to donate the embryos may require separate consent from the egg/sperm donor.

I/We understand and agree that in the event of death or incapacitation of one partner, the embryo(s) will become the sole and exclusive property of the surviving partner, unless otherwise directed by law, a court order or as designated in my/our will. If the surviving partner, friends or family members wish to conceive with these embryos after your death, a legal document indicating this intent will be required.

I/We understand that the cryopreserved embryos will incur a charge according to the Fees for Embryo Cryopreservation and Storage policy of Boston IVF. Cryopreserved embryos will be maintained until specific directives and authorization for those directives are provided by me/us. Options for disposition are discussed in the Consent for Treatment Guideline and consent forms are required at the time of disposition. Boston IVF reserves the right at its sole discretion to make decisions regarding the final disposition of cryopreserved embryos if fee obligations are not met. In the event of divorce or dissolution of the relationship between patient and partner, embryos cannot be used, donated or discarded without the expressed, written consent of both parties or as directed by a court order, even if donor eggs/sperm were used.

VII. Thawing of frozen embryos

To accomplish transfer of frozen embryos the gestational surrogate will be administered estrogen and progesterone to develop the endometrial lining. On the day of the scheduled embryo transfer, the straw(s) containing the frozen embryos will be removed from the storage tank and thawed. After the thawing is completed, the embryos are examined to determine their viability. The chance of pregnancy following this treatment is related to the number and quality of the embryos that are transferred. In an effort to provide the best chance of pregnancy, it may be necessary to thaw a number of straws containing the frozen embryos. This will allow the best quality embryos to be selected for the transfer. The embryos that are not selected for transfer cannot be frozen again and, therefore, will be discarded. On average, 70-80% of frozen embryos will survive the thawing. However, it is possible that none of the embryos will survive the thawing.

TREATMENT OUTCOMES

The chance of success (the delivery of a live born infant) following a cycle of IVF is highly individual. The establishment of a pregnancy following IVF is dependent on many factors, some of which include: the age of the egg donor, the number and quality of the eggs, the quality of the semen sample and the number and quality of the embryos that are transferred. Despite repeated attempts of IVF treatment, there is the possibility that pregnancy will not occur. The following is a list of common events when pregnancy does not lead to the birth of a single baby:

Miscarriage- The risk of miscarriage in the general population is 20-25%. Studies have shown that either there is either no increase or a slight increase in the risk of miscarriage in women who conceive with IVF. Most miscarriages are associated with lower abdominal cramping and bleeding, but do not necessarily require surgical treatment. In some cases, removal of the pregnancy tissue must be accomplished by a surgical procedure called a dilatation and curettage (D&C).

Tubal (Ectopic) Pregnancy- Less than 5% of pregnancies that result from IVF treatment are located outside of the uterine cavity. The majority of ectopic pregnancies are present in the fallopian tube. The chance of tubal pregnancy is greater in women with damaged tubes. If a woman has a tubal pregnancy, she may need surgical treatment, which may involve the removal of the involved tube. Medical treatment with methotrexate may be an option in selected cases.

Multiple Pregnancy- Most multiple pregnancies that occur after IVF treatment result from the implantation of more than one embryo. Therefore, the chance of a multiple pregnancy increases with the number of embryos that are transferred. Approximately 65-70% of pregnancies following the transfer of multiple embryos result in the birth of only one baby. Of the 30-35% of pregnancies that are multiple, approximately two-thirds are twins and one-third are triplets. The chance of a quadruplet pregnancy is 1-2%. Multiple pregnancies are associated with an increased risk of most complications of pregnancy including but not limited to miscarriage, toxemia, congenital anomalies, gestational diabetes in the mother and premature birth. Monozygotic twinning (MZT) is a multiple pregnancy that results from the splitting of a single embryo which will lead to a set of identical twins. The incidence of MZT is increased in pregnancies conceived following IVF and may occur in up to 5% of pregnancies achieved after the transfer of embryos at the blastocyst stage. In addition to the above stated complications associated with a multiple pregnancy with MZT there is a greater chance of twin-to-twin transfusion which can affect the growth of the fetuses and increase the chance of other complications. A multiple pregnancy may also pose increased emotional and financial hardship for a man. If a multiple pregnancy develops, the man may consider a multi-fetal reduction procedure. This procedure, which is performed at three months of pregnancy, reduces number of fetuses to a lower and safer number. Although the success rate is 90-95% a miscarriage may result from the procedure. The best time to discuss the risks of multiple pregnancy and multifetal pregnancy reduction with your physician is before your treatment cycle begins.

Other Risks- Most infants who have been born following in vitro fertilization are normal. The rate of congenital abnormalities (birth defects) in babies conceived naturally is 2-3%. Some published studies have reported that there is an increased risk of birth defects in babies conceived following IVF. It is important to be aware that genetic abnormalities, structural abnormalities, mental retardation and other abnormalities may occur in babies conceived following IVF, as well as, those conceived naturally.

Psychological Risks - IVF can be psychologically stressful. Anxiety and disappointment may occur at any of the phases described above. Significant commitment of time and finances may be required. To help with the stress of the treatment counselors are available at Boston IVF.

There are many complex and sometimes unknown factors, which may prevent the establishment of pregnancy. Known factors, which may prevent the establishment of pregnancy, include, but are not limited to, the following:

1. The egg donor may not respond adequately to the medications.
2. Technical problems including inadequate visualization or the position of the ovaries may prevent the retrieval of the eggs.
3. There may be failure to recover an egg because ovulation has occurred prior to the time of the egg retrieval.
4. Eggs may not be recovered.
5. The eggs may not be normal.
6. The male partner may be unable to produce a semen sample or the semen sample may be of insufficient quantity or quality.
7. Fertilization of the eggs and sperm to form embryos may not occur.
8. Cell division of the embryos may not occur.
9. The embryos may not develop normally.
10. Embryo transfer into the uterus may be technically difficult or impossible.
11. If the transfer is performed, implantation may not result.
12. If implantation occurs, the embryo(s) may not grow or develop normally
13. Equipment failure, infection, technical problems, human error and/or unforeseen factors may result in loss or damage to the eggs, semen sample and/or embryos.

The foregoing general information is based upon the experience and knowledge of the Boston IVF physicians. It is based, in part, upon a review of the literature pertaining to Reproductive Medicine. This information is generally accurate and comprehensive, however, medicine is a dynamic discipline and reproductive medicine in particular is constantly evolving. Estimates of risks factors and the relative benefits of alternative treatment that have been discussed with you represent the best professional judgment of the physicians and caregivers of Boston IVF taking into account your specific needs and circumstances.

ANONYMOUS VERSUS KNOWN EGG DONATION

Egg donors can be either be anonymous donors or known to the recipient. These two categories are detailed below:

Anonymous Donors: Anonymous donors are recruited by a third party agency. Boston IVF only allows donors from approved agencies that adhere to ethical guidelines established by the American Society for Reproductive Medicine. (ASRM). Boston IVF does not allow donors that have been recruited directly by a recipient. Egg donors volunteer to participate in the egg donation with the understanding that they will not know the identity of the recipient. Likewise, the recipient or recipients will not know the identity of the egg donor. Donors recruited through a third party agency sometimes reveal identifying information to the recipient and likewise the recipient sometimes reveals identifying information to the donor. The degree of information exchange varies from agency to agency. As a recipient of donor eggs it is your responsibility to find out in advance the type and amount of personal identifying information that is available to you about the donor and what information about you the donor will receive.

Boston IVF complies with national recommendations for egg donor screening as outlined by the American Society for Reproductive Medicine and the FDA. Donors provide a comprehensive medical, social and family history. In keeping within national guidelines, donors do not provide Boston IVF with copies of medical records from treatment that they may have received during their lifetime. Therefore, an egg donor may omit important information, unintentionally or intentionally, from her history.

Donors take a written psychological test and meet with a social worker for psychological screening. Donors have a complete physical exam including a pelvic examination with tests for the sexually transmitted diseases, gonorrhea and Chlamydia. Donors are also screened for sexually transmitted diseases including HIV and the viruses that cause hepatitis B and C. In addition, donors are re-screened for sexually transmitted diseases a second time within 30 days of the egg retrieval as per FDA regulations.

Unfortunately, no test or screening process in medicine is perfect or 100% accurate. This includes the unintentional transmission of a genetic characteristic, trait, disease potential or actual disease from the donor to the embryo. Furthermore, an infectious disease may escape detection during the screening process and be transmitted to the recipient. Fortunately, it is estimated that such transmission is extremely rare.

Known Donors: Donors in this category are brought to Boston IVF by a specific, designated recipient. The donor knows the identity of the recipient and the recipient knows the identity of the donor. All oocytes retrieved from the known donor are designated for the use of the known recipient. Boston IVF has established guidelines with regard to age of the donor and relationship of the donor to the recipient. Donors that do not meet these guidelines may not be permitted undergo egg donation.

RIGHTS OF THE DONOR AND RECIPIENT

The intentions of the egg donor and recipient are clear and unambiguous from the outset. When the egg donor signs her consent form she explicitly agrees that once the eggs leave her body, she waives any right and relinquishes any claim to the donated eggs as well as any embryos or offspring that might result from their use. The recipient in turn, releases the egg donor from any and all liability for any problem occurring during pregnancy and for any mental or physical disabilities, financial support, care, custody or living expenses, education, health and welfare of the child(ren) born as a result of egg donation. The recipient also accepts complete financial responsibility for the care and storage of any embryos frozen for her during treatment. The recipient has the right to determine the fate of all embryos frozen for her including but not limited to discarding them, donating them to another recipient or donating them for research. Anonymous donors also expect the right to privacy following egg donation. The recipient clearly and unambiguously agrees not to seek the identity of the donor now or in the future.

UNANTICIPATED CHANGES IN THE LAW

State or Federal laws may change in the future that permit the donor and/or recipient to locate one another. There is no way to predict when or if such a change will ever occur. We recommend that you speak with a lawyer about the implications of this possibility.

Legal Issues Concerning the Use of Donor Gametes

I/We understand and acknowledge that Boston IVF has not and is not giving me legal advice. If you have any questions or concerns about the following it is recommended that you consult with a lawyer.

I/We understand that the law in Massachusetts regarding use of donor gametes and the parentage of a child conceived with donor gametes is not completely settled. There is currently one Massachusetts statute in place which states that, *“Any child born to a married woman as a result of artificial [donor] insemination with the consent of her husband, shall be considered the legitimate child of the mother and such husband”*. Mass.G.L.ch. 46 §4B. There are other laws which may or may not apply to my situation, including (among possibly others) an equal rights law, a law on determining maternity (paternity)out-of-wedlock, and law that within Massachusetts recognizes same-sex marriage. I acknowledge that the law is not clear, and may not be settled, regarding use of donor sperm (eggs) for individuals or couples who are not legally married.

If you are in a relationship and not married for the purpose of trying to secure the legal status and security of any resulting child and intended family, I/we understand that Boston IVF strongly recommends a legal consultation and agreement prior to proceeding with sperm donation treatment. The purpose is to allow me to consult with legal counsel experienced in the legal aspects of third-party or collaborative reproduction to answer any questions and to advise as to my respective rights, obligations, and risks, and what steps may be taken to help ensure any resulting child’s legal status. I/we acknowledge that Boston IVF is not in a position to give me legal advice and has not done so.

If we are legally married same-sex couple, Boston IVF strongly recommends we have a legal consultation to investigate what additional steps, including a co-parent adoption, we may wish to take to secure the legal status of our family within and outside of Massachusetts. If this situation applies to you please notify you treatment team to obtain the donor sperm consent requiring both you and your partner's signature.

I/We agree that such child or children conceived and born shall be my legitimate child and agree to assume the entire responsibility of any child born. I/we agree to assume all financial support, care, custody or living expenses, health, welfare, and education of the resultant child or children born.

PRIVACY

Data from your ART 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 assisted reproductive technology cycles performed in the United States annually and report success rates using these data. Because sensitive information will be collected on you, 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 you will not be disclosed to anyone else without your consent.

ACKNOWLEDGMENT OF INFORMED CONSENT AND AUTHORIZATION

I (we) acknowledge that I (we), the undersigned, are voluntarily seeking treatment with **In Vitro Fertilization (IVF) with the transfer of the embryos into a gestational surrogate** in order to conceive a child. I (we) will acknowledge our natural parentage of any child or children born through this treatment.

I (we) have discussed this treatment in detail with a Boston IVF physician and caregivers in language that I (we) understand. I (we) understand the purpose, risks and benefit of the treatment. **I (we) acknowledge that I have read all pages of this consent form and all of my (our) questions concerning the treatment have been fully answered to my (our) satisfaction.**

I (we) am (are) aware that there are other centers in the area that offer this treatment and I (we) have freely chosen to have the treatment at Boston IVF.

I (we) acknowledge that I (we) have undergone medical, psychological and legal counseling that has been met with my (our) satisfaction.

By consenting to treatment at Boston IVF I (we) accept the responsibilities, conditions and risks involved as set out in this document and as explained by the staff of Boston IVF. In addition, I (we) consent to the techniques and procedures used to accomplish this treatment described in this document and as explained by the physicians and staff of Boston IVF.

I (we) understand and acknowledge that medicine is not an exact science and that in cases of doubt Boston IVF physicians and caregivers will exercise their best professional judgment.

I (we) acknowledge and agree that acceptance into treatment and our continued participation is within the sole discretion of Boston IVF. I (we) understand that should this cycle be unsuccessful; it may be determined that further treatment may not be indicated.

I (we) acknowledge that it is my (our) responsibility to notify Boston IVF in writing if I (we) become aware of any information that Boston IVF should have in order to discharge its obligations under this agreement.

I (we) agree to notify BIVF immediately in writing of any change in our marital status including separation or divorce.

I (we) understand that medical information concerning my (our) treatment may be analyzed and could be used in a publication. In accordance with federal law, identifying information and information concerning my (our) treatment will be submitted to a national data registry that publishes statistics on treatment outcomes. In order to obtain this information I give Boston IVF consent to contact any physicians who provided care during and after a pregnancy. I (we) understand that no publication resulting from these or other scientific studies will contain our name or other information that would allow us to be identified.

I (we) understand that Boston IVF complies with national recommendations for egg donation and gestational surrogate screening as outlined by the American Society for Reproductive Medicine. I (we) understand that no test or screening process in medicine is perfect or 100% accurate. Furthermore, some infectious diseases of the gestational surrogate, depending on the incubation period, may escape detection during the screening process and be transmitted to the fetus(es) during the pregnancy.

I (We) have read and understand the section in this consent form describing the rights of the donor and recipient. I (We) accept all responsibility and release the egg donor from any and all liability for any problem occurring during pregnancy and for any mental or physical disabilities, financial support, care, custody or living expenses, education, health and welfare of the child(ren) born as a result of egg donation. I (We) accept complete financial responsibility for the care and storage of any embryos frozen. I (We) understand that anonymous donors expect the right to privacy following egg donation. If I (we) am (are) using an anonymous egg donor, I (we) clearly and unambiguously agree not to seek the identity of the anonymous egg donor now or in the future unless otherwise agreed between the recipient and the donor not through or involving Boston IVF.

