CONSENT TO THAW AND REFREEZE FROZEN EMBRYOS FOR GENETIC TESTING

I/We hereby give our (my) permission to Boston IVF to thaw my/our frozen embryos, perform a biopsy on all viable embryos for genetic testing and then refreeze the embryos waiting for genetic test results.

I/We understand that during this process the embryos may not survive the thawing process, may not be suitable for biopsy or be diagnosed as being genetically abnormal and will be discarded.

This consent serves as an addendum to the previously signed consent forms entitled “Consent form for embryo biopsy with preimplantation genetic testing-aneuploidy” and/or “Consent form for embryo biopsy with preimplantation genetic testing-for disease causing genetic mutations or chromosomal structural rearrangements”

This consent must be signed in front of a Boston IVF witness (or as a default an official Notary) and is valid for 120 days prior to the date of the thaw.

I/We have read the IVF Consent for Treatment Guide in its entirety and have had ample time to reach my/our decision, free from pressure and coercion, and agree to proceed with my/our participation in Assisted Reproduction to thaw, biopsy and refreeze my/our embryos as stated.
Witness of Consent Form (if this form is completed no need to complete notarization form)

Patient Name (print)  Patient Signature  Today’s Date (MM/DD/YYYY)  
/ / 
Date of Birth (MM/DD/YYYY)  

PATIENT- TYPE OF PICTURE IDENTIFICATION: ☐ Driver’s License  ☐ Passport  ☐ Other: _________  
ID NUMBER:________________________  State/Country:_______  Expiration Date: __ / __ / (MM/DD/YYYY)  

Witness Name and Title (print)  Witness Signature  Today’s Date (MM/DD/YYYY)  

Partner Name (if applicable, print)  Partner Signature  Today’s Date (MM/DD/YYYY)  
/ / 
Date of Birth (MM/DD/YYYY)  

PARTNER - TYPE OF PICTURE IDENTIFICATION: ☐ Driver’s License  ☐ Passport  ☐ Other: _________  
ID NUMBER:________________________  State/Country:_______  Expiration Date: __ / __ / Date (MM/DD/YYYY)  

Witness Name and Title (print)  Witness Signature  Today’s Date (MM/DD/YYYY)  

Physician Attestation
The above mentioned patient and partner (if applicable) have been informed and counseled by me and other team members regarding the risks and benefits of the relevant treatment options, including non-treatment. The patient and partner (if applicable) expressed understanding of the information presented during the discussion.  

Physician Name (print)  
Physician signature  
/ / 
Today’s Date (MM/DD/YYYY)
Notarization Form (This form is only needed if not able to have witnessed at Boston IVF)

Patient Name (print)              Patient Signature                       Date of Birth (MM/DD/YYYY)

State of:_________ County of:_________

On this ______ day of ________________ 20____, before me, the undersigned notary public, personally appeared
________________________________________, proved to me through satisfactory evidence of identification, which were______________________________________, to be the person whose name is signed on the proceeding or attached document in my presence.

ID NUMBER:_________________ Expiration Date:_____/_____/_____

________________________ (MM/DD/YYYY)

Today’s Date (MM/DD/YYYY)

Notary Signature

________________________

Title

My appointment expires:_____/_____/_____

________________________ (MM/DD/YYYY)

Partner Name (if applicable, print) Partner Signature                       Date of Birth (MM/DD/YYYY)

State of:_________ County of:_________

On this ______ day of ________________ 20____, before me, the undersigned notary public, personally appeared
________________________________________, proved to me through satisfactory evidence of identification, which were______________________________________, to be the person whose name is signed on the proceeding or attached document in my presence.

ID NUMBER:_________________ Expiration Date:_____/_____/_____

________________________ (MM/DD/YYYY)

Today’s Date (MM/DD/YYYY)

Notary Signature

________________________

Title

My appointment expires:_____/_____/_____

________________________ (MM/DD/YYYY)