# CONSENT TO THAW
## HOMOLOGOUS FROZEN SPERM

**INSTRUCTIONS:**

This consent form gives Boston IVF approval to thaw frozen sperm to be used for either intrauterine insemination or IVF treatment.

- It must be signed/witnessed **no more than 120 days** before the treatment begins.
- Treatment **cannot** be started until all consents are signed.
- Do not make any additions or deletions to the consent.

I hereby give my permission to Boston IVF to thaw my frozen sperm to be used as the sperm source for the infertility treatment that we are undergoing to establish a pregnancy.

**This consent must be signed/witnessed within 120 days of the initiation of the treatment cycle.**

I have been given the opportunity to ask questions, which have been answered to my satisfaction by Boston IVF.

**It is required that you have this document witnessed at Boston IVF, if unable because of distance the default is to have this document officially notarized.**

| | |
|---|---|
| _____ | _____ |
| Signature of Patient | Signature of BIVF Witness or Notary |
| _____ | _____ |
| Printed Name | Printed Name of BIVF Witness or Notary |
| _____ | _____ |
| Date of Birth | ID Type |
| _____ | _____ |
| Telephone # | ID Number and Exp Date |
| _____ | |
| Date | |

_____(State)

On this ____day of _____, 201___, 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.

_____
Notary Public

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