BOSTON IVF

CONSENT TO THAW
FROZEN EGGS

INSTRUCTIONS:

This consent form gives Boston IVF approval to thaw frozen eggs to be used for fertility treatment.

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

I/we hereby give my/our permission to Boston IVF to thaw my/our frozen eggs to be used for the fertility treatment that I/we are undergoing to establish a pregnancy. I/we have been given the opportunity to ask questions, which have been answered to my/our satisfaction by Boston IVF.

Please choose one option:

☐ My/our own eggs

☐ My/our donor eggs

_____ Patient Initials _____ Partner Initials (if applicable)

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BOSTON IVF

Patient Attestation

Patient Name

Date of Birth *(mm/dd/yyyy)*

Patient Signature

Today's Date

Patient – Type of Picture Identification (choose one)

☐ Driver's License

☐ Passport

☐ Other: _____

All 3 of these are required for identification type:

ID Number: _____

State/Country: _____ | *(state for license, country for passport)*

Expiration Date _____ | *(mm/dd/yyyy)*

Partner Attestation

Partner Name

Date of Birth *(mm/dd/yyyy)*

Partner Signature

Today's Date

Partner – Type of Picture Identification (choose one)

☐ Driver's License

☐ Passport

☐ Other: _____

All 3 of these are required for identification type:

ID Number: _____

State/Country: _____ | *(state for license, country for passport)*

Expiration Date: _____ | *(mm/dd/yyyy)*

Witnessing

In-person witnessing applicable only if signing on-site at Boston IVF and not completing electronically via DocuSign

Witness Name

Today's Date

Witness Signature

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