Strong Fertility Center
500 Red Creek Dr, Suite 220
Rochester, NY 14623
585-487-3378

REQUEST TO RECEIVE CRYOPRESERVED EMBYROS

We, _____(Patient)

and _____(Partner)

hereby state that the Strong Fertility Center is aware of our wishes to have our embryos transported from:

_____
_____
_____

This voluntary and informed decision is based upon our desire to use the embryos for further treatment at the Strong Fertility Center. If embryos are generated from a out of state tissue bank which is not licensed by NYS-DOH, then lab has to obtain a permission from NYS before initiating the transfer.

We have read and understand this consent form, and have had the opportunity to ask questions, and all questions were answered in a satisfactory manner.

Signature:_____ Date:_____

Signature:_____ Date:_____

Revised 9/3/13-RS