

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

REQUEST TO TRANSPORT CRYOPRESERVED EMBRYOS

We, _____ (Patient)

And _____ (Partner)

Hereby request that the Strong Fertility Center transfer our embryos to:

(Name and address of institution)

This voluntary and informed decision is based upon our desire to have the thaw and embryo transfer procedures performed at a facility other than the Strong Fertility Center. We have advised the Strong Fertility Center that we have made arrangements for such transfer.

We understand that there may be inconsistencies between facilities and that procedure for dealing with the thaw and transfer of the embryo(s) may differ, with implications for the success of the procedure. We have been advised by the Strong Fertility Center, and understand, that there are risks to the transport of embryos including, but not limited to, loss, spoilage, destruction, and other changes which will render the embryos unusable. We release and indemnify the Strong Fertility Center, the University of Rochester Medical Center (URMC) and their staff from all responsibility and liability involved in the transport of the embryos, from the time the embryos are delivered to the transport agent, and for the success of the thaw and transfer procedures, and from all direct or indirect complications that may result therefrom.

We understand that we are responsible, individually and collectively, for all costs of this procedure.

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

Signature: _____ Date: _____

Signature: _____ Date: _____

Notary: _____ Date: _____