

### Gamete Cryopreservation Consent Form

I, \_\_\_\_\_, wish to cryopreserve and store gametes (sperm or eggs\*) at the Heartland Fertility & Gynecology Clinic (Heartland) to provide the possibility of preserving future fertility that may be lost due to medically necessary treatments I am undergoing.

I understand that cryopreserved gametes may not be viable or suitable for use at the time that they are thawed. Gametes may only be suitable to be used in In Vitro Fertilization. There is no guarantee of successful fertilization, implantation or pregnancy. The risk of abnormal children is not known at this time.

*\*Egg cryopreservation is currently considered experimental*

#### PATIENT'S COVENANTS

##### 1. Provision of Information

As long as I have cryopreserved gametes in storage at Heartland, I hereby agree to contact Heartland at least annually to provide current information indicating my address, telephone number, and intention regarding my cryopreserved gametes. Failure to:

- I. contact Heartland for a period of twelve months;
- II. respond to a request for information from Heartland within 90 days of receipt;
- III. provide a new address or forwarding address where mail is returned to Heartland as undelivered, shall constitute abandonment and signify my desire to terminate storage of Cryopreserved Gametes.

In the event of my failure to comply with (i), (ii) or (iii) above, I instruct Heartland and hereby consent to the disposition of my Cryopreserved Gametes as follows:

*Please write yes or no as indicated and initial beside the applicable option to confirm your instructions*

Initials \_\_\_\_\_

Cryopreserved Gametes to be removed from storage for subsequent disposal (yes/no)\_\_\_\_\_.

2. Payment of Fees

I understand that I am responsible for the costs of cryopreservation and storage of my Cryopreserved Gametes. Cryopreservation and storage fees are due and payable at the time of gamete cryopreservation, and at the beginning of each annual storage interval thereafter. I understand these fees are non-refundable and are not subject to prorated adjustment for partial storage intervals.

Should the yearly fee for storage of my Cryopreserved Gametes remain unpaid for a period of one year after the first invoice is forwarded to my address as it is listed in the clinical records at Heartland, Heartland can conclude that I am no longer interested in storing these specimen(s) and I hereby instruct Heartland to dispose of my Cryopreserved Gametes.

3. Failure to Provide Information or Pay Fees

In the event of my failure to contact Heartland or to pay cryopreservation fees as set out in sections 1 and 2 above, I hereby consent to and instruct Heartland to dispose of the Cryopreserved Gametes as follows:

*Please write yes or no to each of the following options and provide your initials beside the applicable option to confirm your instructions.*

- |   | Initials |
|---|----------|
| I. To remove from storage for subsequent disposal (yes/no)_____                           | _____    |
| II. To be used to improve assisted reproduction procedures (yes/no)_____                  | _____    |
| III. To be used to provide instructions in assisted reproduction procedures (yes/no)_____ | _____    |

4. Death

I acknowledge and confirm that in the event of my death, consent to utilize the Cryopreserved Gametes cannot be granted. I further acknowledge that it is the policy of Heartland not to utilize cryopreserved gametes in the event of my death unless instructions have been included in my will specifically allowing for the use of such cryopreserved gametes. In the event of my death and upon receipt of notification of my death, I hereby instruct Heartland as follows:

*Please write yes or no to each of the following options and provide your initials beside the applicable option to confirm your instructions.*

- |   | Initials |
|---|----------|
| • Dispose of my Cryopreserved Gametes (yes/no)_____   | _____    |
| • Accept written notification of the terms of my will by the executor and follow my wishes as set out in the will (yes/no)_____ | _____    |

*Please note that the use of your Cryopreserved Gametes after your death to create an embryo for your spouse or common-law partner is subject to Federal Regulations under Section 8 of the Assisted Human Reproduction Act. The Act requires your consent to the use of your reproductive gametes after your death. Heartland requires that any written notification set out in your will to Heartland contain such consent and be in accord with Federal Regulations.*

**5. Alternate Contact/Responsible Party**

I hereby name \_\_\_\_\_, as an alternate contact and my representative to assume responsibility for sections 1 and 2 above in the event that I am unable due to illness. I have attached a signed acknowledgement by \_\_\_\_\_ that they have read this form and will be responsible for its provisions in the event that I cannot.

**6. Release**

I agree to absolve, release, indemnify, protect and hold harmless Heartland, its officers, directors, agents and employees, from any and all liability, however remote, resulting from the

cryopreservation and storage of my gametes, including but not limited to the loss or destruction of my cryopreserved gametes, the birth of a physically or mentally abnormal child, subsequent disputes between the parties regarding the control of my cryopreserved gametes, the custody and/or support of any children ultimately born as a result of this procedure, and all legal costs arising there from.

### 7. Independent Legal Advice

Due to the complexity of the legal issues surrounding Cryopreservation and the granting of valid consent, I have been advised to obtain Independent Legal Advice with respect to the execution of the Gamete Cryopreservation Consent Form and with respect to the granting of consent in the event of death, non-payment of fees or failure to maintain contact with Heartland.

I HEREBY:

*Please write yes or no as indicated and initial beside the applicable option to confirm your instructions*

Initials

- a) Attach hereto an original executed Certificate of Independent Legal Advice (yes/no)\_\_\_\_\_
- b) \_\_\_\_\_

Or

- c) Waive my right to obtain Independent Legal Advice having fully understood the nature and effect of executing the Gamete Cryopreservation Consent Form (yes/no)\_\_\_\_\_
- \_\_\_\_\_

### 8. Amendment

No amendments or changes to this consent shall be made by the Donor except if made by the Donor personally in writing

with valid legal witnesses and the written consent of Heartland to such amendment or change.

9. Consent

I have read and understood this document and Schedule A attached hereto. I have discussed this document and additional information with a Heartland physician, who has provided ample opportunity for me to ask any questions regarding Gamete Cryopreservation and who has answered these questions to my satisfaction.

I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. I further acknowledge that this document is by no means a complete record of my conversations with Heartland physicians and staff, and am satisfied that I am sufficiently advised and informed to make this decision.

I understand and accept the conditions, risks and limitations of gamete cryopreservation. In signing this document I request and consent to cryopreservation of my gametes. I understand that my acceptance of gamete cryopreservation as a possibility to preserve future fertility is completely voluntary and that by written notice I may withdraw consent at any time.

I therefore voluntarily consent to the use of cryopreservation to preserve my gametes for potential future use. I am of eighteen (18) years of age or older. (yes/no) \_\_\_\_\_. If no, an emancipated minor, or cosigned by a parent/legal guardian.

DATED on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
NAME

\_\_\_\_\_  
PARENT/LEGAL GARDIAN (IF APLICABLE)

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
WITNESS