MASSACHUSETTS GENERAL HOSPITAL
FERTILITY CENTER

Patient Name: _____ Partner Name: _____

Date of Birth: _____ Date of Birth: _____

MRN: _____ MRN: _____

CONSENT TO THAW CRYOPRESERVED SPERM

I, _____ (Patient), _____ (Date of Birth) request that the Massachusetts General Hospital Fertility Center proceeds with the thawing of my sperm specimen(s) for my current cycle as per your protocol. In signing this release, I state under penalty of prevailing law that my specimen will be used to attempt a pregnancy with my sexually intimate partner. _____ (Partner Name), _____ (Date of Birth)

Patient Signature: _____ Date: _____

MGH IVF Staff Printed Name: _____

MGH IVF Staff Signature: _____

***Notary signature required only if your signature is not witnessed by an MGH Clinical Staff Member**

NOTARY (required if not witnessed by MGH IVF staff) County _____

On this _____day of _____, 20 _____, before me the undersigned notary public, personally appeared _____, provided to me through satisfactory evidence of identification, which were_____, to be the person whose name is signed on the preceding or attached document in my presence.

Notary Signature: _____ Date: _____

Commission Expiration Date: _____ (seal)