Consent to Thaw Cryopreserved Oocytes

Must be signed for each thaw cycle
Consent Expiration: 6 months

I, ___________________________________________ (Patient), hereby direct the Massachusetts General Hospital Fertility Center, in accordance with its policies and procedures, to proceed with a cryopreserved Oocyte(s) thaw cycle. I understand that this is a final decision.

Signature must be witnessed by an MGH IVF staff member or notary public.

Patient Signature: ___________________________________________ Date: ______________

MGH IVF Staff Printed Name: ______________________________________________________

MGH IVF Staff Signature: ________________________________________________________

____________________________
NOTARY (required if not witnessed by MGH 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)