## Consent to Receive and Store Cryopreserved Embryo(s), Patient/Partner

We,	(Patient), and	(Partner) have previously consented to
cryopreservation (freezing) and stor	rage of our embryo(s) for future use, at:	
-		(name of Facility)
-		(street)
-		(city, state, zip)
-		(telephone and fax)
We acknowledge that I currently ha	ve embryo(s) cryopreserved and	stored with the embryology laboratory at Facility.
We consent to the transfer of all ou Health.	r cryopreserved embryo(s) from the Faci	lity to the embryology laboratory at Regional One
	d Regional One Health's control may occ is not liable for any losses associated wit	our during transport and agree that Regional One Health h the transport of our embryo(s).
supervision of the Laboratory Direct		ology laboratory at Regional One Health, under the lover, and access to, our embryo(s) as may be necessary stody of our embryo(s).
fourteen (14) days' advanced writte	n notice, provided that all amounts due	pratory at Regional One Health at any time upon from us are paid in full, including any packing, shipping, embryo(s) to another location, as so directed by us.
viable cells present after being thaw control of the embryology laborator	ved and that such risks are inherent in the	ion potential by adversely affecting the percentage of e freezing and storage process and are beyond the itions have been made to us concerning the fertility or at Regional One Health.
		nin five (5) years from the date the embryo(s) are or up to one (1) year after the embryo(s) are created.
to Fairfax Cryobank (or other cryopr with the cryopreservation storage fa Regional One Health has received no	reservation storage facility chosen by us) acility; (ii) paid the applicable fee for stor	ear period, they will be shipped by Regional One Health provided that we have (i) signed a storage agreement age to the cryopreservation storage facility; and (iii) tion storage facility. We understand it is our to the cryopreservation storage facility.
		o provide cryopreservation storage. We further isclosed to the cryopreservation storage facility and we
period, we understand that the em	bryo(s) will be considered abandoned. I	ty for the frozen embryo(s), within the one-year f our embryo(s) are determined to be abandoned by d Partner initial beside their choice and cross out the
research purposes. Any research pe embryo(s) will not be continued bey disposition releases any and all right	rformed shall be conducted pursuant to yond the 14 <sup>th</sup> day of development and wi ts we may have in the cryopreserved em such work. If state and federal guidelines	of Tennessee Health Science Center (UTHSC) for applicable federal and state guidelines. Research on II not be transferred to attempt pregnancy. This bryo(s) and any cell lines, intellectual property, or prohibit such research or if remaining embryo(s) are
Regional One Hea	lth	

1 Copy - Medical Record 1 Copy - Patient 1 Copy - Partner

Embryo(s), Patient/Partner

Consent to Receive and Store Cryopreservation

Form No. ROH.554 (Created 5/15) \*OB0481\*

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Patient's Initials	
Partner's Initials	

If at any time during the one-year period the Patient or the Partner dies, the remaining partner shall provide Regional One Health with a certified copy of the death certificate, and at which time, the disposition of the frozen embryo(s) shall be as follow (both Patient and Partner initial beside their choice and cross out the other choices):  a. thaw and destroy all stored embryo(s). This disposition directs Regional One Health to dispose of all embryos in a manner consistent with any federal and state law.  b. remaining partner shall have sole custody of the embryo(s) and shall have the right to determine their disposition until his/her death.  c. the remaining partner shall donate the embryo(s) to an Embryo Adoption program of his/her choice and will be responsible for any extra fees required to accomplish such a choice.  d. all the embryo(s) shall be donated to the University of Tennessee Health Science Center (UTHSC) for research purposes. Any research performed shall be conducted pursuant to applicable federal and state guidelines. Research on embryo(s) will not be continued beyond the 14 <sup>th</sup> day of development and will not be transferred to attempt pregnancy. This disposition releases any and all rights we may have in the cryopreserved embryo(s) and any rell lines intellectual property, or royalties that may be derived from such work. If state or federal guidelines prohibit such research or if remaining embryo(s) are unused, all embryo(s) may be thawed and destroyed.  If at any time during the one-year period both Patient and Partner die, the disposition of the frozen embryo(s) shall be as follow (both Patient and Partner initial beside their choice and cross out the other choices):  a. thaw and destroy all stored embryo(s). This disposition directs Regional One Health to dispose of all embryo(s) in a manner consistent with any federal or state law.  b. all the ebryo(s) shall be donated to the University of Tennessee Health Science Center (UTHSC) for research purposes. Any research performed shall be con	Consent to Receive and Store Cryopreserved Embryo(s), Patient/Partner
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	We hereby release Regional One Health, UT Regional One Physicians, Inc., and their respective employees, agents, directors, officers, and contractors ("the Releasees") from any claim of injury or damage, known or unknown, that might result should our frozen embryo(s) cease to be viable while in the custody of the embryology laboratory at any of the Releasees.



Consent to Receive and Store Cryopreservation Embryo(s), Patient/Partner Form No. ROH.554 (Created 5/15) \*OB0481\*

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atient's	Initials	
artner's	Initials	

## Consent to Receive and Store Cryopreserved Embryo(s), Patient/Partner

We acknowledge and agree that in the event loss, damage, or destruction of the embryo(s) occurs for any reason whatsoever, except as provided in the paragraph above, that the actual damage as a result thereof would be impracticable or extremely difficult to determine. Accordingly, we agree that in the event any or all of our stored embryo(s) are lost, damaged, or destroyed for any reason, including, without limitation as a result of the negligence of Regional One Health, we shall be entitled to liquidation damages in the amount equal to the storage fee paid for the term of the storage agreement in which such loss, damage, or destruction occurred.

We further release, discharge, indemnify and forever hold harmless the Releasees from any and all liability and responsibility of any nature whatsoever that may result from complications of pregnancy, childbirth, delivery or from the birth of an abnormal infant or infants in any respect, or from the heredity or hereditary tendencies of such infant or infants, or from any other adverse consequences that may arise in connection with or as a result of the procedures and services discussed herein.

We understand that all information obtained about us during the program will be handled confidentially and that our identities will not be revealed without our consent. However, specific medical details may be revealed in professional publications as long as our identities are concealed.

We understand it is our responsibility to inform the embryology laboratory at Regional One Health of any future changes in our mailing address. Our current mailing address is: \_\_\_\_\_(street) (city, state, zip) We acknowledge that we have fully reviewed and comprehend the contents of this consent form. We each have had the opportunity to ask any questions we might have and those questions have been answered to our satisfaction. We each acknowledge that embryo cryopreservation and/or storage is being performed at our request and with our consent. We each acknowledge and affirm that we have given our consent and signed this consent form without coercion or compulsion and of our own free will. We acknowledge that a copy of this consent has been given to us. Patient's Signature Partner's Signature Date Date Patient's Printed Name Partner's Printed Name **Physician Attestation** The above mentioned patient and partner (if applicable) have been informed and counseled by me and others regarding the risks and benefits of the relevant treatment option, including non-treatment. The patient and partner (if applicable) expressed understanding of the information presented during the discussion. Physician Signature Date Physician Printed Name [Notary Page to Follow]



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	Patient's Initials

Partner's Initials \_\_\_\_\_

## Consent to Receive and Store Cryopreserved Embryo(s), Patient/Partner

## [Notary Page for: Consent to Receive and Store Cryopreserved Embryo(s), Patient/Partner

STATE of	)			
	) :SS			
COUNTY of	)			
The foregoing i	nstrument was acknowledged befo	re me this day of	, 20	_, by
	, referred to	n this consent form as "Patient	.".	
My commission	expires:		_·	
	<del>.</del>			
	N	otary Public		
STATE of	1			
51A1E 01	/ ) :SS			
COUNTY of	)			
The foregoing in	nstrument was acknowledged befo	re me this day of	, 20	_, by
	, referred to	n this consent form as "Partne	r".	
My commission	expires:			
	$\overline{N}$	otary Public		



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