OVAGEN FERTILITY™
THE NEXT GENERATION

Consent for the Release and Transportation of Frozen Embryos/Oocytes/Sperm from Ovagen Fertility

I/We,_____and_____do

hereby request and agree to have_____(number) ❍embryos ❍oocytes ❍vials of sperm transferred

TO:

_____

_____

_____

FROM:
Ovagen Fertility
6500 N. Mopac, Bldg. 3, Suite 3102
Austin, Texas 78731
Phone: (512) 610-7474

Laboratory Contact:_____Phone_____

a) By public carrier via (please circle) **Fairfax / UPS / FedEx** or **Other** :_____
(on the dates coordinated by Ovagen Fertility/IVF Coordinator)

OR

b) Transfer vials/ampules to an appropriate storage/shipment tank which will be collected by _____ and who assumes responsibility for the transport from Ovagen Fertility and agrees on the conditions below.

I/We have been fully advised and understand that there are certain inherent risks in the process of freezing, shipping and thawing such embryos/ oocytes/sperm including, but not limited to, damage to the embryo/oocytes/sperm during the freezing process, handling during shipment, loss during shipment, liquid nitrogen tank failure during shipment and storage, method of thawing, method of rehydration and removal of cryoprotectants, and method of culture prior to replacement in the uterus, and that I/we are willing to assume all of these risks.

I/We have been informed and understand the risks of transporting frozen embryos/oocytes/sperm from Ovagen Fertility to another clinical or laboratory facility. I/We acknowledge and agree that Ovagen Fertility cannot assume any responsibility for the transportation, condition, or survival of any of these embryos/oocytes/sperm.

I/We fully understand and accept that Ovagen Fertility, its physicians, laboratory directors, and laboratory personnel do not assume responsibility or liability for the transportation, condition, or survival of the embryos/oocytes/sperm or the physical, mental, or other characteristics of any child or children born as a result of the use of these embryos/oocytes/sperm.

_____ _____
Patient Signature Partner Signature

_____ _____
Patient SS# DOB Partner SS# DOB

_____ _____
Witness Date

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I/We realize that insurance will not cover the transportation and handling costs of the above transaction. I/We authorize Ovagen Fertility to provide the following payment information to the public carrier for the handling and round-trip shipment fees. I/We understand that if I/We handle transportation to the new facility directly that I/We will be responsible for the cost of Ovagen Fertility's shipment container if it is not returned in good condition to Ovagen Fertility within five business days. I/We authorize Ovagen Fertility to charge the following credit card in the event of damage or loss of the shipment container.

Name that appears on card (printed)_____

Credit Card Number_____CCV_____Expiration Date_____

Cardholder Signature_____

NOTARY REQUIRED IF CONSENT IS NOT COMPLETED IN PERSON AT OVAGEN FERTILITY

Before me, the undersigned authority, personal appeared _____ and _____, who, being by me duly sworn, deposed as follows: We are over eighteen years of age, competent of making informed consent, and knowledgeable of the information presented within this document.

_____ _____

Patient Partner

Sworn to and subscribed before me on the_____day of_____, 20_____ .

_____

NOTARY PUBLIC

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