

## CONSENT TO THAW AND REFREEZE FROZEN EMBRYOS FOR GENETIC TESTING

I/We hereby give our (my) permission to Boston IVF to thaw my/our frozen embryos, perform a biopsy on all viable embryos for genetic testing and then refreeze the embryos waiting for genetic test results.

I/We understand that during this process the embryos may not survive the thawing process, may not be suitable for biopsy or be diagnosed as being genetically abnormal and will be discarded.

This consent serves as an addendum to the previously signed consent forms entitled "Consent form for embryo biopsy with preimplantation genetic testing-aneuploidy" and/or "Consent form for embryo biopsy with preimplantation genetic testing-for disease causing genetic mutations or chromosomal structural rearrangements"

This consent must be signed in front of a Boston IVF witness (or as a default an official Notary) and is valid for 120 days prior to the date of the thaw.

I/We have read the IVF Consent for Treatment Guide in its entirety and have had ample time to reach my/our decision, free from pressure and coercion, and agree to proceed with my/our participation in Assisted Reproduction to thaw, biopsy and refreeze my/our embryos as stated.



## Witness of Consent Form (if this form is completed no need to complete notarization form)

Patient Name (print)	Patient Signature	/ / Today's Date (MM/DD/YYYY)
// Date of Birth (MM/DD/YYYY)		
PATIENT- TYPE OF PICTURE IDE	NTIFICATION: 🗆 Driver's License	Passport Other:
ID NUMBER:	State/Country:	Expiration Date: / / (MM/DD/YYYY)
Witness Name and Title (print)	Witness Signature	/ / Today's Date (MM/DD/YYYY)
Partner Name (if applicable, print)	Partner Signature	/ / Today's Date (MM/DD/YYYY)
// Date of Birth (MM/DD/YYYY)		
PARTNER - TYPE OF PICTURE IE	DENTIFICATION: 🗆 Driver's License	Passport Other:
ID NUMBER:	State/Country:	Expiration Date: / / Date (MM/DD/YYYY)
Witness Name and Title (print)	Witness Signature	/ / Today's Date (MM/DD/YYYY)

## **Physician Attestation**

The above mentioned patient and partner (if applicable) have been informed and counseled by me and other team members regarding the risks and benefits of the relevant treatment options, including non-treatment. The patient and partner (if applicable) expressed understanding of the information presented during the discussion.

Physician Name (print)

Physician signature

/ Today's Date (MM/DD/YYYY)



## Notarization Form (This form is only needed if not able to have witnessed at Boston IVF)

		/ / /
ient Name (print)	Patient Signature	Date of Birth (MM/DD/YYYY)
State of:	County of:	-
On this day of	20	_, before me, the undersigned notary public,
personally appeared		
		_, proved to me through satisfactory evidence c
identification, which were		, to be the person
whose name is signed on the p	roceeding or attached do	cument in my presence.
ID NUMBER:	Expirat	ion Date: / / (MM/DD/YYYY)
/ / Today's Date (MM/DD/YYYY)		
Notary Signature		_
Title My appointment expires:	/ / DD/YYYY)	-
tner Name (if applicable, print)	Partner Signature	/ / / Date of Birth (MM/DD/YYYY)
State of:	County of:	_
On this day of	20	_, before me, the undersigned notary public,
personally appeared		
		_, proved to me through satisfactory evidence o
identification, which were		, to be the person
whose name is signed on the p	roceeding or attached do	cument in my presence.
ID NUMBER:	Expirat	ion Date: / // (MM/DD/YYYY)
/ / Today's Date (MM/DD/YYYY)		
Notary Signature		_