BOSTON IVF

CONSENT TO THAW FROZEN SPERM

INSTRUCTIONS:

This consent form gives Boston IVF approval to thaw frozen sperm to be used for either intrauterine insemination or IVF treatment.

- It must be signed/witnessed **no more than 120 days** before treatment begins.
- Treatment **cannot** be started until all consents are signed.
- Do not make any additions or deletions to the consent.

I/we hereby give my/our permission to Boston IVF to thaw my/our frozen sperm to be used as the sperm source for the infertility treatment that I/we are undergoing to establish a pregnancy.

I/we have been given the opportunity to ask questions, which have been answered to my/our satisfaction by Boston IVF.

Please choose one option:

☐ My own Sperm Sample

☐ My/our Donor Sperm Sample (directly purchased from a Commercial Donor Sperm Bank or Known Sperm Donor)

______ Patient Initials ______ Partner Initials (if applicable)

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BOSTON IVF

Patient Attestation

Patient Name

Date of Birth
(mm/dd/yyyy)

Patient Signature

Today's Date

Patient – Type of Picture Identification (choose one)

☐ Driver's License

☐ Passport

☐ Other: ____________

All 3 of these are required for identification type:

ID Number: ____________

State/Country: ____________ | *(state for license, country for passport)*

Expiration Date ____________ | *(mm/dd/yyyy)*

Partner Attestation

Partner Name

Date of Birth
(mm/dd/yyyy)

Partner Signature

Today's Date

Partner – Type of Picture Identification (choose one)

☐ Driver's License

☐ Passport

☐ Other: ____________

All 3 of these are required for identification type:

ID Number: ____________

State/Country: ____________ | *(state for license, country for passport)*

Expiration Date: ____________ | *(mm/dd/yyyy)*

Witnessing

In-person witnessing applicable only if signing on-site at Boston IVF and not completing electronically via DocuSign

Witness Name

Today's Date

Witness Signature

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