SHER INSTITUTE FOR REPRODUCTIVE MEDICINE CENTRAL ILLINOIS, LLC

CONSENT TO TRANSFER CRYOPRESERVED EMBRYOS/OOCYTES/SPERM

I/We, _____, and _____, if applicable,

Female Patient Name Partner Name

am/are requesting that my/our frozen embryos/oocytes/sperm ("Specimen") be transferred from the Sher Institute for Reproductive Medicine - Central Illinois, LLC facility to:

Sher Institute for Reproductive Medicine – St. Louis
Name Receiving Facility

555 N. New Ballas Rd., Ste. 150
Address

Address

Creve Coeur, MO 63141
City, State, Zip

314-983-9000
Telephone

In furtherance of the above, I/we understand and acknowledge:

1. It is my/our responsibility to arrange for the pickup, transport and delivery of my/our Specimen to the Receiving Facility.
2. It is my/our responsibility to make an appointment with the laboratory staff at SIRM for the pickup of the Specimen.
3. It is my/our responsibility to make an appointment with the laboratory staff at the Receiving Facility for delivery of the Specimen.
4. I/We acknowledge that I/we are financially responsible for all costs associated with the storage release, transport and transfer of the Specimen.
5. I/We acknowledge that SIRM will not be held responsible for loss or damage that may occur to the Specimen after it has been released from our facility.
6. I/We acknowledge that SIRM can only confirm the release of the Specimen and can not be held responsible for its quality and condition upon arrival at the Receiving Facility.

Agreement and Consent

I/We hereby confirm that the Specimen released for transfer from SIRM is my/our property and that I/we have read and understand all the above.

_____	_____	_____
Date	**Signature of Female Patient**	**Witness (SIRM Staff)**
_____	_____	_____
Date	**Signature of Partner**	**Witness (SIRM Staff)**

**Note: If you and your partner are unable to have this consent witnessed by a SIRM laboratory staff member, both signatures must be notarized.

Notarization

State of _____, County of _____ss., I, the undersigned, a Notary Public in and for the said County in the State aforesaid, do hereby certify that _____(Female patient) and _____ (Partner, as applicable) personally known to me as the same persons whose names are subscribed to the foregoing document appeared before me this day in person, and acknowledge that she/they signed, sealed and delivered said document as her/their free and voluntary act, for the use and purposes therein set forth. Given under my hand and official seal this____day of _____, 20____.

My commission expires on _____. _____