EMORY
REPRODUCTIVE CENTER

550 Peachtree St. Suite 1800, Atlanta GA 30308
(404) 778-3401 FAX (404) 686 4501 CLIA ID 11D0897047

Place Patient Sticker Here

Name: ______________________________

MRN: ______________________________

DOB: ______________________________

AUTHORIZATION FOR SHIPMENT OF FROZEN EMBRYOS

We, ____ , ____________________, and
Patient Name Date of Birth

____ , ____________________,
Partner's Name Date of Birth

hereby authorize and instruct the Emory Reproductive Center of the Emory Clinic, Inc. to remove all of our remaining frozen embryos from storage for transport to a Fertility Center in (please list the name, address, phone number and contact person of the designated facility):

____

____

____

We instruct that the embryos are to be transported by the following means and agree to pay fees associated wih the shipment

- ☐ Reprotech (recommended for long-term storage)
- ☐ Cryoport Commercial courier (recommended to transfer to another fertility clinic)
- ☐ Federal Express
- ☐ Other (please specify) ____

We understand that there are material risks to frozen embryos during transport which could result in the damage or loss of embryo viability. We accept all responsibility for any losses or damage to the embryos as a result of our desire to have the embryos moved. We agree to absolve, release, indemnity, protect and hold harmless the Emory Reproductive Center, Emory Clinic, Inc., its officers, directors, agents and employees from any and all liability associated with the handling and transport of our frozen embryos to the above designated facility.

On signing this form, we acknowledge that we have read the above statement regarding the release of my embryos, and we wish to take full responsibility for the release.

______________________________ ____________ ____________
Signature of Patient Date Time

______________________________ ____________ ____________
Signature of Partner Date Time

______________________________ ____________ ____________
Signature of Staff Member Date Time

OR

______________________________ ____________ ____________
Print Name of Notary Signature of Notary Date Time

Seal

Instructions to Patient

In order for this consent for the shipment of frozen embryos to be acceptable, we must receive a copy of the notarized form from the Patient and Partner. This form can be sent via patient portal, or mailed to Emory at the address below. Alternatively, the Patient and Partner may sign this form in the presence of an Emory Reproductive Center clinical staff member with a state-issued ID.

Emory Reproductive Center
Attn: Clinic Operations Manager
550 Peachtree St., Suite 1800
Atlanta, GA 30308

______________________________ ____________
Provider Signature Date