MASSACHUSETTS GENERAL HOSPITAL
FERTILITY CENTER

Consent To Thaw Cryopreserved Oocytes

Must be signed for each thaw cycle
Consent Expiration: 6 months

I, _____ (Patient), hereby direct the Massachusetts General Hospital Fertility Center, in accordance with its policies and procedures, to proceed with a cryopreserved Ooctye(s) thaw cycle. I understand that this is a final decision. **Signature must be witnessed by an MGH IVF staff member or notary public.**

Patient Signature: _____ Date: _____

MGH IVF Staff Printed Name: _____

MGH IVF Staff Signature: _____

NOTARY (required if not witnessed by MGH staff) County _____

On this _____day of _____, 20 _____, before me the undersigned notary public, personally appeared _____, provided to me through satisfactory evidence of identification, which were_____, to be the person whose name is signed on the preceding or attached document in my presence.

Notary Signature: _____ Date: _____

Commission Expiration Date: _____ (seal)