Delaware Valley Institute of Fertility & Genetics
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CONSENT FOR THE THAW OF CRYOPRESERVED OOCYTES

I/We, (Intended Parent (s)_____ agree to the thawing of _____ cryopreserved oocytes I understand that not every thawed oocyte may be fertilized and cultured to be suitable for transfer and that in certain occasions an embryo transfer may not be possible.

I/We herby certify that I/We have read all above information. I/We have had the opportunity to address all of our questions and concerns and that I/We have received satisfactory answers thereto. I/We agree to undergo the transfer of the thawed embryos with the gestational carrier. In so doing, we assume the obligation to comply with the stated requirements and restraints and we accept all the risks. My/Our participation is voluntary. My/Our participation is not pursuant to any contractual agreement with any other individual or entity.

Intended Parent Name Print	Intended Parent Signature	Date
Intended Parent Name Print (If Applicable)	Intended Parent Signature (If Applicable)	Date
DVIF&G Witness Signature	Print	Date
Physician's Name Print	Physician's Signature	Date