University of Michigan Health System
Assisted Reproductive Technologies Program

Request for the Release and Transfer of Cryopreserved Oocytes From the University of Michigan Health System

I have been a participant in the In Vitro Fertilization (IVF) Program offered by the University of Michigan Health System. I participated in a procedure in which human oocytes were preserved by a method known as cryopreservation for later use in attempting to initiate a successful pregnancy.

The University of Michigan Health System is currently storing oocytes for me. I now wish to have all of my unused cryopreserved oocytes transferred from the University of Michigan Health System to a different medical facility.

Complete name, shipping address and phone number of receiving facility:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I understand that it is my responsibility to arrange the mode of transportation. I understand that there is an unforeseen risk of damage to or destruction of the oocytes during transport. We agree that neither the University of Michigan Health System nor any of its physicians or employees will be held liable for any destruction or damage to the oocytes during transport. I understand that the University of Michigan Health System makes no guarantees or representations about the viability of the oocytes in the event of transport to another institution. I release the University of Michigan Health System and its employees or physicians from any further responsibility toward the oocytes or from any responsibility for the use of the oocytes after they have been transferred from the University of Michigan Health System.

I have had the opportunity to ask questions about this procedure and my questions have been answered.

___________________________
Patient’s name (print)

___________________________
UMHS registration number

___________________________
Patient’s signature

___________________________
Notary Public
(or witness if done in person at the UMHS)