

**CONNECTICUT FERTILITY ASSOCIATES
CONSENT TO PERFORM THERAPEUTIC DONOR INSEMINATION
WITH ANONYMOUS DONOR SPERM**

Female Name: _____ **SS#:** _____ - _____ - _____

Partner Name: _____ **SS#:** _____ - _____ - _____

We (I), the undersigned, request, authorize and consent to the performance of one or more Therapeutic Donor insemination(s) with sperm from an anonymous donor, by Connecticut Fertility Associates, and as appropriate, its employees, contractors, consultants and authorized agents.

The therapeutic insemination procedure, its risks, benefits, and alternatives have been explained to us (me) by the staff of Connecticut Fertility Associates. The process involves obtaining the necessary sperm from a donor who shall not be advised of our (my) identity, nor shall we (I) ever be advised of the identity of the donor unless we (I) have purchased sperm for a bank with donors who are willing to be identified in the future. We (I) also agree that an anonymous sperm donor will be selected by us (me) with the help of Connecticut Fertility Associates.

We (I) consent to any blood tests, infectious disease or genetic testing and any other tests, interviews or screening required for donor insemination. We (I) understand that the cost of this testing will be born by us (me). We (I) understand that donors are screened for infectious diseases, genetic diseases and family history of transmissible diseases. In spite of this screening, we (I) understand that there is, nonetheless, a risk that these diseases or conditions may be transmitted to the sperm recipient, her partner and/or a child.

We (I) agree to notify Connecticut Fertility Associates of any genetic disease that occurs in a child conceived by these inseminations. We (I) understand that there is no guarantee that these inseminations will result in a pregnancy. We (I) further understand that within the normal human population a certain percentage (approximately 2%) of children are born with physical or mental defects and that the occurrence of such defects is beyond the control of physicians. We (I) therefore understand and agree that Connecticut Fertility Associates and its physicians do not assume responsibility for the physical and mental characteristics of any child or children born as a result of therapeutic insemination. We (I) also understand and accept that any pregnancy carries with it the risk of obstetrical complications and/or spontaneous abortion.

We (I) also understand that Connecticut Fertility Associates, and/or sperm banks providing sperm samples for therapeutic insemination, make best efforts to record the number of offspring of any given donor but that a small risk of inadvertent consanguinity (intermarriage between siblings) exists when children are born to different parents in the same geographic area.

As appropriate, it is further agreed that from conception, I _____, *as husband/partner*, accept the act of insemination as my own and agree:

- a. That such child or children conceived or born shall be considered to be my legitimate children and heirs of my body and
- b. That I hereby waive forever any right which I might have to disclaim or omit the child or children as my legitimate heir or heirs, and
- c. That such child or children conceived or born shall be considered to be in all respects, including descent and distribution of my property, a child or children of my body.
- d. That I may be contacted periodically to verify my continued consent to participate in this treatment.

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We (I) further agree, jointly and severally, that we (I) will not seek support for the child or children, or any other payment from the donor, physician, or Connecticut Fertility Associates. We further agree that, if the child or children should seek support or any of payment from the donor, the physician, or Connecticut Fertility Associates, we will indemnify and hold harmless the donor, the physician, and Connecticut Fertility Associates.

We agree and consent that the partner/husband signing this consent will be contacted periodically by mail or during visits to Connecticut Fertility Associates to verify his continued participation and consent to this treatment and that he may withdraw his consent at any time by notifying Connecticut Fertility Associates in writing.

We (I) expect this procedure to be performed with not less than the customary standard of care. We (I) understand the risks and benefits as outlined, and further understand and agree that Connecticut Fertility Associates shall be responsible only for acts of negligence on its part and the part of its employees, contractors, consultants and authorized agents.

We (I) have had the opportunity to review this treatment and ask questions of our (my) physician concerning alternative options to Therapeutic Donor insemination, including adoption and no treatment, in an effort to help us overcome our (my) infertility.

The nature of Therapeutic Donor Insemination has been explained to us (me), together with the known risks. We (I) understand the explanation that has been given to us. We (I) have had the opportunity to ask any questions we (I) might have and those questions have been answered to our (my) satisfaction. Any further questions can be addressed to Connecticut Fertility Associates or to its Medical Director, Dr. Michael B. Doyle, at 203-373-1200, or 203-855-1200, or 203-799-1200. We acknowledge that Therapeutic Donor Insemination is being performed at our (my) request and with our (my) consent. We (I) understand, agree and acknowledge that we (I) are (am) not married to individuals who are not parties to this informed consent.

Signature of Patient	Date	Signature of Witness	Date
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Signature of Partner	Date	Signature of Witness	Date
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This consent has been read by and discussed with the patient and her partner, where applicable.

Signature of CFA Physician	Date
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