



We, _____ (“Recipient”) and _____ (“Recipient’s Partner”), the undersigned are each over eighteen (18) years of age.

We authorize Dr. _____ (“Physician”) and her/his assistants at Lucile Salter Packard Children’s Hospital at Stanford (“LPCH”) to perform one or more inseminations on the Recipient with sperm obtained from Recipient’s Partner for the purpose of making Recipient pregnant.

The insemination procedure, including a description of the screening process that each of us will undergo, and the risks inherent in that process and the procedure, have been explained to us by the Physician. We have had an opportunity to discuss the insemination procedure with the Physician. We also have had an opportunity to discuss alternatives to the insemination procedure, including non-treatment and adoption.

We understand that unknown or undesirable genetic characteristics of the Recipient’s Partner and/or the Recipient might be expressed in a child resulting from insemination, like any child resulting from sexual intercourse. We also understand that any child resulting from insemination has the usual risks of developmental, psychological and physical disabilities and/or illness like any child conceived other than through insemination.

With full knowledge of the above, we hereby state our express agreement and intent that we shall conclusively be presumed to be the sole legal parents of any fetus(es) and/or child(ren) resulting from the insemination. As the legal parents, we hereby agree to assume all parental, custodial and testamentary rights and obligations with respect to such fetus(es) and/or child(ren). We understand that according to California law, if a woman is inseminated with the consent of her husband, the husband is treated in law as the natural father of any child thereby conceived. Notwithstanding the foregoing, we understand that if we are not legally married to each other, the legal status of Recipient’s Partner as co-parent of such child(ren) is as yet uncertain. We acknowledge that we have had an opportunity to consult independently with legal counsel.

1. Risks Associated with Insemination and Pregnancy.

- a. Failure of the Insemination to Result in Pregnancy. The success of the insemination cannot be guaranteed. We understand that development of pregnancy is dependent on factors some of which cannot be tested or predicted in advance, and no guarantees of pregnancy rates can be given.
- b. Risk of Infection. We understand and acknowledge that LPCH has screened the Recipient’s Partner for evidence of infection with HIV, agents of viral hepatitis (HBV and HCV), human T lymphotropic virus-1 (HTLV-1), and syphilis; or that we have provided to the Stanford REI Center a written report of such screening from a bona fide laboratory. We understand that despite such screening it is possible to acquire an infectious disease, including HIV (the virus that causes AIDS), from the insemination procedure.



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- c. Complications of Pregnancy. If pregnancy results, there are risks of miscarriage, genetic defects, birth defects, stillbirths, and multiple births. There are many medical risks to both the pregnant woman and the baby(ies) associated with pregnancy itself whether conceived through intercourse or through the insemination procedure. Pregnancy complications, which may include, without limitation, high blood pressure, diabetes, liver disease, hemorrhage or seizures, may lead to serious permanent damage to the mother or death.
 - d. Abnormalities and Birth Defects. So far, there is no evidence that the insemination procedure causes an increased chance of abnormalities in the baby(ies). The risk of birth defects may or may not be higher than the usual risk of birth defects (2 to 5%) when conception occurs following intercourse.
 - e. Psychological Risks. The psychological and emotional risks of voluntary participation in an insemination program to the Recipient and/or her partner and family are currently not known.
 - f. Legal Status. We understand that there may be future changes in the law related to insemination. We have had an opportunity to seek independent legal counsel.
2. Release of Liability. We hereby release Lucile Salter Packard Children's Hospital at Stanford, Stanford University, Physician and the employees and agents thereof (collectively, "Stanford") from any and all claims and/or liability arising out of or in any way connected with our voluntary participation in the insemination program, except to the extent of any negligence or willful misconduct on the part of Stanford.
3. Financial Responsibility. We understand that we are solely financially responsible for the costs of all services and items provided by LPCH as part of the insemination procedures. We understand that we are also solely financially responsible for any costs related to any medical complications which the Recipient may experience. We have received the LPCH Schedule of Fees and have had the opportunity to meet with a financial counselor.

We understand that LPCH is not responsible for any costs related to the insemination procedures or any related medical complications, should they occur. I (Recipient) certify that I have the following medical insurance, which will cover any medical complications I experience:

Name of Carrier, Policy No. and Group Name

4. Marital Status. (check one)
- a. I (Recipient) certify that I am
 - unmarried
 - married to the Partner named in this consent form
 - married to someone other than the named Partner



Medical Record Number

Patient Name

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Addressograph or Label - Patient Name, Medical Record Number

b. I (Recipient's Partner) certify that I am: (check one)

- unmarried
- married to Recipient
- married to someone other than Recipient

OUR SIGNATURES BELOW INDICATE THAT WE HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT WE CONSENT TO THE PERFORMANCE OF INSEMINATION ON RECIPIENT WITH RECIPIENT'S PARTNER'S SPERM. WE HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS HAVE BEEN ANSWERED TO OUR SATISFACTION. WE UNDERSTAND THAT WE CAN WITHDRAW FROM THE PROGRAM AT ANY TIME WITHOUT IT AFFECTING OUR FUTURE THERAPY OR CLINICAL CARE AND THAT THERE WILL BE NO PENALTY FOR SUCH WITHDRAWAL.

Signature of Recipient

Date

Time

Signature of Recipient's Partner

Date

Time

I hereby certify that I have discussed the insemination procedure and its risks and benefits with the Recipient and the Recipient's Partner named above.

Signature of Physician

Date

Time

I hereby certify that _____
(Name of Recipient)

and _____,
(Name of Recipient's Partner)

who have presented documentation to me showing them to be the individuals named herein, appeared before me and signed the above consent to artificial insemination.

Signature of Witness (LPCH)

Date

Time

This consent is valid for one year or until the birth of a live child, whichever occurs first.