Strong Fertility Center
500 Red Creek Dr., Suite 220, Rochester, NY 14623
Phone: 585.487.3378 Fax: 585.334.8998

Patient Name: Patient DOB: MRN:

CONSENT TO TRANSFER CRYOPRESERVED GAMETES OR EMBRYOS

I/We, ____ hereby confirm the request to have the frozen reproductive specimens designated below transferred from the custody of Strong Fertility Center (hereinafter referred to as "SFC") to another physician, clinic, laboratory, or healthcare facility (hereinafter referred to as "facility") of our choosing as indicated below.

Please check one: ☐ Oocytes (eggs) ☐ Embryos ☐ Sperm

Facility Name: ____

Facility Contact Name:

Facility Contact Phone Number: