INFORMED PSYCHOLOGICAL CONSENT
FOR ANONOMOUS DONOR RECIPIENTS

I/we agree to participate in this psychosocial and psychoeducational counseling as part of the process of being a recipient of anonymous donor gametes or embryos. This counseling will include discussions of my/our psychosocial history, current mental status, current level of support from significant others, marital and/or social adjustment, and psychological well-being. There may be psychological risks associated with my/our participation in the proposed fertility treatments, including those that might arise during the counseling. The risk of psychological harm occurring in each individual circumstance cannot always be accurately predicted.

It is impossible to state with any degree of certainty or specificity the psychological implications of my participation in an assisted reproductive technology (ART) program. Choosing to participate with ART is a decision with lifelong consequences and questions and/or concerns may arise over time. I/we understand that I/we may wish to consult a mental health professional now or in the future regarding any emotional issues that may occur from my/our participation in ART.

I/we also understand that this counseling does not completely address the legal, ethical or religious ramifications of this procedure. Should I/we need further information concerning this, I/we understand that I/we should obtain appropriate legal or religious counsel.

By signing this document, I/we acknowledge and consent to the following:

- I/we understand that there may be psychological risks of my participation in ART and have been informed of them, and I freely assume them.
- I/we acknowledge that the mental health professional is not responsible for predicting or ensuring my current or future emotional responses or well-being.
- I/we release the mental health profession from claims of liability related to any psychological harm that I/we may suffer as a result of my/our participation in counseling, or related to my/our participation in the proposed treatment, and accept the risks of psychological harm.
- I/we appreciate that there is no certainty that I/we will achieve any benefit either from this counseling or my participation in ART.
- I/we also understand that there is no guarantee that the outcome of this counseling or my/our participation in ART will be a positive one.

I/we have read and been offered a copy of this consent form. I/we have received and read a copy of HIPPA client services agreement.

<table>
<thead>
<tr>
<th>Written Name and Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Written Name and Signature</th>
<th>Date</th>
</tr>
</thead>
</table>