WBASNY

The Women's Bar Association of the State of New York

presents

Convention 2021
Continuing Legal Education Series

Whose Baby is it Anyway

May 22, 2021
10:45 am - 11:45 pm

Presenters: Susan Baldomar
Andrea Braverman, Ph.D.
Denise Seidelman, Esq.
Yifat Shaltiel, Esq.

New York's Child Parent Security Act:

Denise Seidelman, Esq.

RUMBOLD & SEIDELMAN, LLP
ADOPTION AND REPRODUCTIVE LAW

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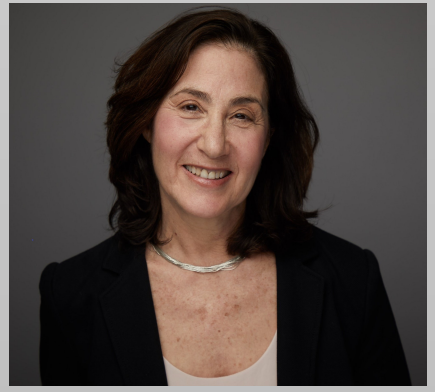
- Director of New York Attorneys for Adoption & Family Formation (NYAAFF)
- Trustee (2016-2020) Academy of Adoption & Assisted Reproduction Attorneys (AAAA)
- Drafter and main coordinator of legislative efforts in support of the CPSA
- Frequent lecturer on issues involving adoption, assisted reproduction and surrogacy



RUMBOLD & SEIDELMAN, LLP

ADOPTION AND REPRODUCTIVE LAW

CPSA went into effect on February 15, 2021

- The CPSA determines the parentage of children born with the assistance of medical technology
- Establishes clear legal mechanisms for securing parentage

IVF and need for Assisted Reproduction

- IVF - a procedure where eggs and sperm are mixed together (fertilized) outside of the human body.
- The fertilized egg is grown to pre-embryo stage and transferred to someone's uterus
- Sperm can be contributed by one person, egg by another and gestated by a third person who may or may not intend to be the parent
- Intended Parent(s) may be infertile, a carrier for a genetic disorder or unable to conceived or gestate a child without the assistance of a third party ("Third Party Reproduction ")
    - Same sex intended parents
    - Single men or woman
    - Medically induced infertility - Cancer patients rendered infertile as a result of treatment

Intent as a substitute for biology or gestation

Johnson v Calvert- 5 Cal.4th 84, 851 P.2d 776 (Sup Ct California, 1993)

When children born through Third Party Reproduction their parentage is determined by the intent" of the parties at the time of conception

"*We conclude that although [THE LAW] recognizes both genetic consanguinity and giving birth as means of establishing a mother and child relationship, when the two means do not coincide in one woman, she who intended to procreate the child-that is, she who intended to bring about the birth of a child that she intended to raise as her own-is the natural mother under California law.*"

Progeny of Johnson v Calvert

Buzzanca v Buzzanca, 72 Cal. Rptr.2d 280 (Cal. Ct. App 1998)

Facts: Embryo created using Donor Sperm and Donor Egg and embryo gestated by Gestational Carrier. Intended Parents divorce during the Gestational Carrier's pregnancy and Intended Father disclaims the Child.

Held: Intended Father is the Child's legal parent "given his "initiating role in the conception of the child."

New York statutory law before the CPSA

DRL § 73. Legitimacy of children born by artificial insemination

Child born to a married woman by means of artificial insemination performed by persons duly authorized to practice medicine and with the consent in writing of the woman and her husband, shall be deemed the legitimate, birth child of the husband and his wife for all purposes.

DRL Article 8 § 122: Surrogate parenting contracts are contrary to the public policy of this state, and are void and unenforceable.

- Harsh criminal and financial sanctions for violating the prohibition on compensated surrogacy.

Legislators expressed concerns

That NY will become hub of international commercial surrogacy

The perceived imbalance of power between IP and GC

Commodification of Children and the act of giving birth to a child.

Emotional and Medical impact of surrogacy and egg donation on surrogate and egg donor.

Unregulated matching programs (agencies) and attorneys failing to follow best practices/

Principles Underlying the CPSA

- Never applies to children conceived through sexual intercourse
- Parentage determined at time of conception
- Court Order of Parentage recognizes the existing parental relationship
  - Contrast adoption where the court creates the parent/child relationship
- Order not contingent on best interest finding
- A person who donates their gametes to another person(s) is not a parent.
- Person who participates in conception with intent to be a parent is a parent (regardless of genetic connection).
- (Marriage neutral) Intended Parents do not have to be married to one another
- Gender neutral (same sex and different sex couples treated the same)
- Single parents – right to an order declaring them the only legal parent.

CPSA - Surrogacy Basics

- Only applies to gestational surrogacy arrangements
  - compensated traditional/genetic surrogacy still illegal
  - uncompensated traditional/genetic surrogacy still unenforceable
- Strict requirements for enforceable surrogacy agreement
- Surrogate may receive compensation
- Strict residency requirements
  - NY IPs can work with NY or non-NY surrogate
  - NY surrogate can only work with NY IPs if they want to use NY law
- If agreement complies with statutory requirements –parties can obtain an order of parentage pre-birth – which becomes effective at birth

Surrogate Eligibility – Statute & Regulations

- 21-45 years old
- At least one prior uncomplicated pregnancy
- No more than 5 previous deliveries (no more than 3 via cesarean section)
- Stable and supportive family environment
- US citizen or lawful permanent resident
- NY resident for at least 6 months (only if one or more IPs has not been a NY resident for at least 6 months)
- Completed a medical and psychological evaluation
- Represented by independent counsel licensed in NY
- Single, married with spouse participating, or married but physically separated for 3 years or living separate and apart pursuant to a separation agreement or judgment
- Not automatically disqualified because she's on public assistance

Surrogacy – Intended Parent Eligibility (Statutory)

- At least 1 is a US citizen or lawful permanent resident
- At least one has been a NY resident for at least 6 months
  - This may change to being a requirement only if the surrogate has not been a NY resident for 6 months
- Represented by independent counsel licensed in NY
- Single individual, unmarried intimate partners, married couple together, or married individual but physically separated for 3 years or living separate and apart pursuant to a separation agreement or judgment

Right to Legal Counsel

- NY licensed attorneys for both IPs and Surrogate
    - Can also have counsel from another state (ex. CT surrogate could also have CT counsel)
- Represented throughout the duration of the surrogacy arrangement
- Statute details requirements of attorney retainer agreement

Life & Disability Insurance under the CPSA

- Life Insurance
  - Current - $750,000 of standard term life insurance (or the highest amount the Surrogate is eligible for if less than that) in place from prior to starting medications for the embryo transfer until 12 months after pregnancy ends
  - Proposed – allow the alternative of contractual liability or accidental death insurance
- Disability insurance
  - Current – required if requested by the Surrogate
  - Proposed – if requested, disability or other insurance to cover lost wages or reimbursement for lost wages required

Medical Insurance under the CPSA

- Current
  - A single insurance policy with a "term" lasting from before the medications for embryo transfer start until 12 months after the pregnancy ends
  - Must include preconception care, prenatal care, major medical treatments, hospitalizations and behavioral health care
  - Premiums, copays and deductibles paid by IPs (unless uncompensated – then she can waive payment but not the insurance coverage itself)

Medical Insurance under the CPSA

- Proposed
  - Preconception – screenings, medication, embryo transfer, monitoring and complications covered by IPs by insurance and/or funds in escrow
    - If no pregnancy – funds released 6 months after termination of Surrogacy Agreement
  - Pregnancy – one or more policies in place prior to or immediately upon confirmation of pregnancy with coverage in place until 12 months after the pregnancy ends that cover prenatal care, childbirth and postnatal care
    - Co-pays and deductibles paid for by IPs but premiums only to the extent there is any additional cost to the Surrogate (same time period for these)
  - Uncompensated Surrogacy – Surrogate can waive all payments (but not the insurance coverage)

Last Will & Testament

- Required to be executed prior to the Surrogate starting medications
  - Designate a guardian for the child(ren) to be born
  - Authorize their executor to perform their obligations under the surrogacy agreement

Surrogate Medical Decision-Making

- Surrogate right to make all decisions regarding herself and her pregnancy including:
  - whether to consent to C-section , multiple embryo transfer etc.
  - right to utilize services of a health care professional of her own choosing.
  - provisions in the agreement to the contrary are void and unenforceable.
  - **"This article does not diminish the right of the person acting as surrogate to terminate or continue a pregnancy"**

Escrow

- Base compensation and reasonable anticipated additional expenses deposited with an independent escrow agent prior to the Surrogate staring medications
  - Independent
    - NOT the parties or their attorneys
    - Can be the surrogacy matching program IF it's owned or managed by a NY licensed attorney
  - Must be licensed, bonded and insured
    - Exception – attorney-owned
  - Must consent to jurisdiction of NY courts for all proceedings related to enforcement of the escrow agreement

Surrogates' Bill of Rights

- Must be given to Surrogate at first consult by attorney and matching program
- Applies to Surrogates residing in NY regardless of whether they are following another state's laws AND surrogates residing outside of NY but following NY law
- Specific rights
  - Health and welfare decisions
  - Independent legal counsel
  - Health insurance and medical costs
  - Counseling
  - Life insurance
  - Right to terminate the Surrogacy Agreement before she becomes pregnant

Surrogacy Matching Programs

- Definition
  - "…agency, agent, business, or individual engaged in, arranging, or facilitating transactions contemplated by a surrogacy agreement, regardless of whether such agreement ultimately comports with the requirements of article five-C of the family court act."
  - Excludes parties to the Surrogacy Agreement and their attorneys
    - Indicates that attorneys can match (likely unintended)
- Must be licensed by the NY DOH if facilitating transactions associated with a surrogacy agreement under the CPSA and
  - Doing business in NY OR
  - Surrogate resides in NY OR
  - Any medical procedure occurs in NY

DOH Regulations - Clinics

- Potentially prohibited from working with a surrogacy agency that is not licensed in NY if surrogates resides in NY or medical procedure occurs in NY (independent journeys are ok)
- Establish policies and procedures re: selection and evaluation of surrogates and IPs
- Adhere to all tissue bank regulations
- Obtain informed consent from all parties
- Conflict of interest policy
- Recommended – **surrogate, partner, and intended parents all have different health care providers to avoid conflicts**
- Register with DOH by 6/16/21

Surrogacy Agreement: FCA §581-403

- Signed and verified or witnessed by 2 people
- **Executed prior to the Surrogate starting medications associated with embryo transfer**
- Base compensation and anticipated expenses to be deposited with an independent escrow agent prior to the start of medications
- Disclosure of details of insurance coverage including any co-payments and deductibles.
- IPs to execute Wills prior to embryo transfer
- Acknowledge receipt of the Surrogate's Bill of Rights
- Notice that the compensation may affect eligibility for public benefits
- IPs rights not assignable

Parentage Proceeding – FCA § 581-203

- Can file any time after the surrogacy agreement is signed
- Judgment of Parentage
  - IPs are the legal parents from birth
  - Surrogate (and spouse) are not parents
  - Donors (if any) are not parents
  - IPs to be listed on birth certificate as parents
- Court file sealed but parties and child can have the right to access the file (including the identify of Surrogate and known donors)

Conforming vs. Non-conforming Agreements

- Attorney for GC and IP must submit a certification to the court with their court filing (for the parentage order) that the agreement complies with the requirements of the CPSA
  - If the agreement is in compliance – upon the birth of the child - the IPs are the legal parents of the child **by operation of law** (technically do not need an order to be the parent – order evidences the fact that the IP is the parent)
- If certification can't be made because of a non-material deviation
  - the court may enforce agreement and issue order of parentage if it finds the agreement is in substantial compliance with the CPSA
    - examples
      - Perhaps took medication before agreement in effect
      - Not provided with copy of bill of rights
      - Attorney retainer agreement doesn't contain all statutory requirements

Agreement with Material Deviation

- **Where the Agreement is NOT is substantial compliance**
  - court will determine parentage **based on the intent of the parties, taking into account the best interests of the child. An intended parent's absence of genetic connection to the child is not a sufficient basis to deny that individual a judgment of legal parentage.**
    - NY courts unlikely to lightly disregard the defect in the agreement
      - Will likely appoint an attorney for the child
      - Litigation could be protracted

PART L

Section 1. The family court act is amended by adding a new article 5-C to read as follows:

ARTICLE 5-C

JUDGMENTS OF PARENTAGE OF CHILDREN CONCEIVED THROUGH ASSISTED

REPRODUCTION OR PURSUANT TO SURROGACY AGREEMENTS PART 1. General provisions (581-101 - 581-102)

2. Judgment of parentage (581-201 - 581-206)

3. Child of assisted reproduction (581-301 - 581-307)

4. Surrogacy agreement (581-401 - 581-409)

5. Payment to donors and persons acting as surrogates (581-501 -

581-502)

6. Surrogates' bill of rights (581-601 - 581-607) 7. Miscellaneous provisions (581-701 - 581-704)

PART 1

GENERAL PROVISIONS Section 581-101. Purpose.

581-102. Definitions.

§ 581-101. Purpose. The purpose of this article is to legally establish a child's relationship to his or her parents where the child is conceived through assisted reproduction except for children born to a person acting as surrogate who contributed the egg used in conception. This article and all governmental measures adopted pursuant thereto should comply with existing laws on reproductive health and bodily integrity.

§ 581-102. Definitions. (a) "Assisted reproduction" means a method of causing pregnancy other than sexual intercourse and includes but is not limited to:

1. intrauterine or vaginal insemination;

2. donation of gametes;

3. donation of embryos;

4. in vitro fertilization and transfer of embryos; and

5. intracytoplasmic sperm injection.

(b) "Child" means a born individual of any age whose parentage may be determined under this act or other law.

(c) "Compensation" means payment of any valuable consideration in excess of reasonable medical and ancillary costs.

(d) "Donor" means an individual who does not intend to be a parent who produces gametes and provides them to another person, other than the individual's spouse, for use in assisted reproduction. The term does not include a person who is a parent under part three of this article. Donor also includes an individual who had dispositional control of an embryo or gametes who then transfers dispositional control and releases all present and future parental and inheritance rights and obligations to a resulting child.

(e) "Embryo" means a cell or group of cells containing a diploid complement of chromosomes or group of such cells, not a gamete or gametes, that has the potential to develop into a live born human being if transferred into the body of a person under conditions in which gestation may be reasonably expected to occur.

(f) "Embryo transfer" means all medical and laboratory procedures that are necessary to effectuate the transfer of an embryo into the uterine cavity.

(g) "Gamete" means a cell containing a haploid complement of DNA that has the potential to form an embryo when combined with another gamete. Sperm and eggs shall be considered gametes. A human gamete used or intended for reproduction may not contain nuclear DNA that has been deliberately altered, or nuclear DNA from one human combined with the cytoplasm or cytoplasmic DNA of another human being.

(h) "Independent escrow agent" means someone other than the parties to a surrogacy agreement and their attorneys. An independent escrow agent can, but need not, be a surrogacy program, provided such surrogacy program is owned or managed by an attorney licensed to practice law in the state of New York. If such independent escrow agent is not attorney owned, it shall be licensed, bonded and insured.

(i) "Surrogacy agreement" is an agreement between at least one intended parent and a person acting as surrogate intended to result in a live birth where the child will be the legal child of the intended parents.

(j) "Person acting as surrogate" means an adult person, not an intended parent, who enters into a surrogacy agreement to bear a child who will be the legal child of the intended parent or parents so long as the person acting as surrogate has not provided the egg used to conceive the resulting child.

(k) "Health care practitioner" means an individual licensed or certified under title eight of the education law, or a similar law of another state or country, acting within his or her scope of practice.

(l) "Intended parent" is an individual who manifests the intent to be legally bound as the parent of a child resulting from assisted reproduction or a surrogacy agreement provided he or she meets the requirements of this article.

(m) "In vitro fertilization" means the formation of a human embryo outside the human body.

(n) "Parent" as used in this article means an individual with a parent-child relationship created or recognized under this act or other law.

(o) "Participant" is an individual who either: provides a gamete that is used in assisted reproduction, is an intended parent, is a person acting as surrogate, or is the spouse of an intended parent or person acting as surrogate.

(p) "Record" means information inscribed in a tangible medium or stored in an electronic or other medium that is retrievable in perceivable form.

(q) "Retrieval" means the procurement of eggs or sperm from a gamete provider.

(r) "Spouse" means an individual married to another, or who has a legal relationship entered into under the laws of the United States or of any state, local or foreign jurisdiction, which is substantially equivalent to a marriage, including a civil union or domestic partnership.

(s) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(t) "Transfer" means the placement of an embryo or gametes into the body of a person with the intent to achieve pregnancy and live birth.

PART 2

JUDGMENT OF PARENTAGE Section 581-201. Judgment of parentage.

581-202. Proceeding for judgment of parentage of a child

conceived through assisted reproduction.

581-203. Proceeding for judgment of parentage of a child

conceived pursuant to a surrogacy agreement.

581-204. Judgment of parentage for intended parents who are

spouses.

581-205. Inspection of records.

581-206. Jurisdiction, and exclusive continuing jurisdiction.

§ 581-201. Judgment of parentage. (a) A civil proceeding may be maintained to adjudicate the parentage of a child under the circumstances set forth in this article. This proceeding is governed by the civil practice law and rules.

(b) A judgment of parentage may be issued prior to birth but shall not become effective until the birth of the child.

(c) A petition for a judgment of parentage or nonparentage of a child conceived through assisted reproduction may be initiated by (1) a child, or (2) a parent, or (3) a participant, or (4) a person with a claim to parentage, or (5) social services official or other governmental agency authorized by other law, or (6) a representative authorized by law to act for an individual who would otherwise be entitled to maintain a proceeding but who is deceased, incapacitated, or a minor, in order to legally establish the child-parent relationship of either a child born through assisted reproduction under part three of this article or a child born pursuant to a surrogacy agreement under part four of this article.

§ 581-202. Proceeding for judgment of parentage of a child conceived through assisted reproduction. (a) A proceeding for a judgment of parentage with respect to a child conceived through assisted reproduction may be commenced:

(1) if the intended parent or child resides in New York state, in the county where the intended parent resides any time after pregnancy is achieved or in the county where the child was born or resides; or

(2) if the intended parent and child do not reside in New York state, up to ninety days after the birth of the child in the county where the child was born.

(b) The petition for a judgment of parentage must be verified.

(c) Where a petition includes the following truthful statements, the court shall adjudicate the intended parent to be the parent of the child:

(1) a statement that an intended parent has been a resident of the state for at least six months or if an intended parent is not a New York state resident, that the child will be or was born in the state within ninety days of filing; and

(2) a statement from the gestating intended parent that the gestating intended parent became pregnant as a result of assisted reproduction; and

(3) in cases where there is a non-gestating intended parent, a statement from the gestating intended parent and non-gestating intended parent that the non-gestating intended parent consented to assisted reproduction pursuant to section 581-304 of this article; and

(4) proof of any donor's donative intent.

(d) The following shall be deemed sufficient proof of a donor's donative intent for purposes of this section:

(1) in the case of an anonymous donor or where gametes or embryos have previously been released to a gamete or embryo storage facility or in the presence of a health care practitioner, either:

(i) a statement or documentation from the gamete or embryo storage facility or health care practitioner stating or demonstrating that such gametes or embryos were anonymously donated or had previously been released; or

(ii) clear and convincing evidence that the gamete or embryo donor intended to donate gametes or embryos anonymously or intended to release such gametes or embryos to a gamete or embryo storage facility or health care practitioner; or

(2) in the case of a donation from a known donor, either: a. a record from the gamete or embryo donor acknowledging the donation and confirming that the donor has no parental or proprietary interest in the gametes or embryos. The record shall be signed by the gestating intended parent and the gamete or embryo donor. The record may be, but is not required to be, signed:

(i) before a notary public, or

(ii) before two witnesses who are not the intended parents, or

(iii) before a health care practitioner; or

b. clear and convincing evidence that the gamete or embryo donor agreed, prior to conception, with the gestating parent that the donor has no parental or proprietary interest in the gametes or embryos.

(e)(1) In the absence of evidence pursuant to paragraph two of this subdivision, notice shall be given to the donor at least twenty days prior to the date set for the proceeding to determine the existence of donative intent by delivery of a copy of the petition and notice pursuant to section three hundred eight of the civil practice law and rules. Upon a showing to the court, by affidavit or otherwise, on or before the date of the proceeding or within such further time as the court may allow, that personal service cannot be effected at the donor's last known address with reasonable effort, notice may be given, without prior court order therefore, at least twenty days prior to the proceeding by registered or certified

mail directed to the donor's last known address. Notice by publication shall not be required to be given to a donor entitled to notice pursuant to the provisions of this section.

(2) Notwithstanding the above, where sperm is provided under the supervision of a health care practitioner to someone other than the sperm provider's intimate partner or spouse without a record of the sperm provider's intent to parent notice is not required.

(f) In cases not covered by subdivision (c) of this section, the court shall adjudicate the parentage of the child consistent with part three of this article.

(g) Where the requirements of subdivision (c) of this section are met or where the court finds the intended parent to be a parent under subdivision (e) of this section, the court shall issue a judgment of parentage:

(1) declaring, that upon the birth of the child, the intended parent or parents is or are the legal parent or parents of the child; and

(2) ordering the intended parent or parents to assume responsibility for the maintenance and support of the child immediately upon the birth of the child; and

(3) if there is a donor, ordering that the donor is not a parent of the child; and

(4) ordering that:

(i) Pursuant to section two hundred fifty-four of the judiciary law, the clerk of the court shall transmit to the state commissioner of health, or for a person born in New York city, to the commissioner of health of the city of New York, on a form prescribed by the commissioner, a written notification of such entry together with such other facts as may assist in identifying the birth record of the person whose parentage was in issue and, if such person whose parentage has been determined is under eighteen years of age, the clerk shall also transmit forthwith to the registry operated by the department of social services pursuant to section three hundred seventy-two-c of the social services law a notification of such determination; and

(ii) Pursuant to section forty-one hundred thirty-eight of the public health law and NYC Public Health Code section 207.05 that upon receipt of a judgment of parentage the local registrar where a child is born will report the parentage of the child to the appropriate department of health in conformity with the court order. If an original birth certificate has already been issued, the appropriate department of health will amend the birth certificate in an expedited manner and seal the previously issued birth certificate except that it may be rendered accessible to the child at eighteen years of age or the legal parent or parents.

§ 581-203. Proceeding for judgment of parentage of a child conceived pursuant to a surrogacy agreement. (a) The proceeding may be commenced (1) in any county where an intended parent resided any time after the surrogacy agreement was executed; (2) in the

county where the child was born or resides; or (3) in the county where the surrogate resided any time after the surrogacy agreement was executed.

(b) The proceeding may be commenced at any time after the surrogacy agreement has been executed and the person acting as surrogate and all intended parents are necessary parties.

(c) The petition for a judgment of parentage must be verified and include the following:

(1) a statement that the person acting as surrogate or at least one of the intended parents has been a resident of the state for at least six months at the time the surrogacy agreement was executed; and

(2) a certification from the attorney representing the intended parent or parents and the attorney representing the person acting as surrogate that the requirements of part four of this article have been met; and

(3) a statement from all parties to the surrogacy agreement that they knowingly and voluntarily entered into the surrogacy agreement and that the parties are jointly requesting the judgment of parentage.

(d) Where the court finds the statements required by subdivision (c) of this section to be true, the court shall issue a judgment of parentage, without additional proceedings or documentation:

(1) declaring, that upon the birth of the child born during the term of the surrogacy agreement, the intended parent or parents are the only legal parent or parents of the child;

(2) declaring, that upon the birth of the child born during the term of the surrogacy agreement, the person acting as surrogate, and the spouse of the person acting as surrogate, if any, is not the legal parent of the child;

(3) declaring that upon the birth of the child born during the term of the surrogacy agreement, the donors, if any, are not the parents of the child;

(4) ordering the person acting as surrogate and the spouse of the person acting as surrogate, if any, to transfer the child to the intended parent or parents if this has not already occurred;

(5) ordering the intended parent or parents to assume responsibility for the maintenance and support of the child immediately upon the birth of the child; and

(6) ordering that:

(i) Pursuant to section two hundred fifty-four of the judiciary law, the clerk of the court shall transmit to the state commissioner of health, or for a person born in New York city, to

the commissioner of health of the city of New York, on a form prescribed by the commissioner, a written notification of such entry together with such other facts as may assist in identifying the birth record of the person whose parentage was in issue and, if the person whose parentage has been determined is under eighteen years of age, the clerk shall also transmit to the registry operated by the department of social services pursuant to section three hundred seventy-two-c of the social services law a notification of the determination; and

(ii) Pursuant to section forty-one hundred thirty-eight of the public health law and NYC Public Health Code section 207.05 that upon receipt of a judgement of parentage the local registrar where a child is born will report the parentage of the child to the appropriate department of health in conformity with the court order. If an original birth certificate has already been issued, the appropriate department of health will amend the birth certificate in an expedited manner and seal the previously issued birth certificate except that it may be rendered accessible to the child at eighteen years of age or the legal parent or parents.

(e) In the event the certification required by paragraph two of subdivision (c) of this section cannot be made because of a technical or non-material deviation from the requirements of this article; the court may nevertheless enforce the agreement and issue a judgment of parentage if the court determines the agreement is in substantial compliance with the requirements of this article. In the event that any other requirements of subdivision (c) of this section are not met, the court shall determine parentage according to part four of this article.

§ 581-204. Judgment of parentage for intended parents who are spouses. Notwithstanding or without limitation on presumptions of parentage that apply, a judgment of parentage may be obtained under this part by intended parents who are each other's spouse. Nothing in this section requires intended parents to be married to each other in order to be jointly declared the parents of the child.

§ 581-205. Inspection of records. Court records relating to proceedings under this article shall be sealed, provided, however, that the office of temporary and disability assistance, a child support unit of a social services district or a child support agency of another state providing child support services pursuant to title IV-d of the federal social security act, when a party to a related support proceeding and to the extent necessary to provide child support services or for the administration of the program pursuant to title IV-d of the federal social security act, may obtain a copy of a judgment of parentage. The parties to the proceeding and the child shall have the right to inspect and make copies of the entire court record, including, but not limited to, the name of the person acting as surrogate and any known donors.

§ 581-206. Jurisdiction, and exclusive continuing jurisdiction. (a) Proceedings pursuant to this article may be instituted in the supreme or family court or surrogates court.

(b) Subject to the jurisdictional standards of section seventy-six of the domestic relations law, the court conducting a proceeding under this article has exclusive, continuing

jurisdiction of all matters relating to the determination of parentage until the child attains the age of one hundred eighty days.

PART 3

CHILD OF ASSISTED REPRODUCTION Section 581-301. Scope of article.

581-302. Status of donor.

581-303. Parentage of child of assisted reproduction.

581-304. Consent to assisted reproduction.

581-305. Limitation on spouses' dispute of parentage of child of

assisted reproduction.

581-306. Effect of embryo disposition agreement between intended

parents which transfers legal rights and

dispositional control to one intended parent.

581-307. Effect of death of intended parent.

§ 581-301. Scope of article. This article does not apply to the birth of a child conceived by means of sexual intercourse.

§ 581-302. Status of donor. A donor is not a parent of a child conceived by means of assisted reproduction where there is proof of donative intent under subdivision (d) of section 581-202 of this article.

§ 581-303. Parentage of child of assisted reproduction. (a) An individual who provides gametes for, or who consents to, assisted reproduction with the intent to be a parent of the child with the consent of the gestating parent as provided in section 581-304 of this part, is a parent of the resulting child for all legal purposes.

(b) The court shall issue a judgment of parentage pursuant to this article upon application by any participant.

§ 581-304. Consent to assisted reproduction. (a) Where the intended parent who gives birth to a child by means of assisted reproduction is a spouse, the consent of both spouses to the assisted reproduction is presumed and neither spouse may challenge the parentage of the child, except as provided in section 581-305 of this part.

(b) Where the intended parent who gives birth to a child by means of assisted reproduction is not a spouse, the consent to the assisted reproduction must be in a record in such a manner as to indicate the mutual agreement of the intended parents to conceive and parent a child together.

(c) The absence of a record described in subdivision (b) of this section shall not preclude a finding that such consent existed if the court finds by clear and convincing evidence that at the time of the assisted reproduction the intended parents agreed to conceive and parent the child together.

§ 581-305. Limitation on spouses' dispute of parentage of child of assisted reproduction. (a) Neither spouse may challenge the marital presumption of parentage of a child created by assisted reproduction during the marriage unless the court finds by clear and convincing evidence that one spouse used assisted reproduction without the knowledge and consent of the other spouse.

(b) Notwithstanding the foregoing, a married individual may use assisted reproduction and the marital presumption shall not apply if the spouses:

(1) are living separate and apart pursuant to a decree or judgment of separation or pursuant to a written agreement of separation subscribed by the parties thereto and acknowledged or proved in the form required to entitle a deed to be recorded; or

(2) have been living separate and apart for at least three years prior to the use of assisted reproduction.

(c) The limitation provided in this section applies to a spousal relationship that has been declared invalid after assisted reproduction or artificial insemination.

§ 581-306. Effect of embryo disposition agreement between intended parents which transfers legal rights and dispositional control to one intended parent. (a) An embryo disposition agreement between intended parents with joint dispositional control of an embryo shall be binding under the following circumstances:

(1) it is in writing;

(2) each intended parent had the advice of independent legal counsel prior to its execution, which may be paid for by either intended parent; and

(3) where the intended parents are married, transfer of legal rights and dispositional control occurs only upon divorce.

(b) The intended parent who transfers legal rights and dispositional control of the embryo is not a parent of any child conceived from the embryo unless the agreement states that he or she consents to be a parent and that consent is not withdrawn consistent with subdivision (c) of this section.

(c) If the intended parent transferring legal rights and dispositional control consents to be a parent, he or she may withdraw his or her consent to be a parent upon written notice to the embryo storage facility and to the other intended parent prior to transfer of the embryo. If he or she timely withdraws consent to be a parent he or she is not a parent for any purpose including support obligations but the embryo transfer may still proceed.

(d) An embryo disposition agreement or advance directive that is not in compliance with subdivision (a) of this section may still be found to be enforceable by the court after balancing the respective interests of the parties except that the intended parent who divested him or herself of legal rights and dispositional control may not be declared to be a parent for any purpose without his or her consent. The parent awarded legal rights and dispositional control of the embryos shall, in this instance, be declared to be the only parent of the child.

§ 581-307. Effect of death of intended parent. If an individual who consented in a record to be a parent by assisted reproduction dies before the transfer of eggs, sperm, or embryos, the deceased individual is not a parent of the resulting child unless the deceased individual consented in a signed record that if assisted reproduction were to occur after death, the deceased individual would be a parent of the child, provided that the record complies with the estates, powers and trusts law. Any rights of the child born after the death of an intended parent may be enforced by a government agency authorized by law, including but not limited to a department of social services.

PART 4

SURROGACY AGREEMENT Section 581-401. Surrogacy agreement authorized.

581-402. Eligibility to enter surrogacy agreement.

581-403. Requirements of surrogacy agreement.

581-404. Surrogacy agreement: effect of subsequent spousal

relationship.

581-405. Termination of surrogacy agreement.

581-406. Parentage under compliant surrogacy agreement.

581-407. Insufficient surrogacy agreement.

581-408. Absence of surrogacy agreement.

581-409. Dispute as to surrogacy agreement.

§ 581-401. Surrogacy agreement authorized. (a) If eligible under this article to enter into a surrogacy agreement, a person acting as surrogate, the spouse of the person acting as surrogate, if applicable, and the intended parent or parents may enter into a surrogacy agreement which will be enforceable provided the surrogacy agreement meets the requirements of this article.

(b) A surrogacy agreement shall not apply to the birth of a child conceived by means of sexual intercourse, or where the person acting as surrogate contributed the egg used in conception.

(c) A surrogacy agreement may provide for payment of compensation under part five of this article.

§ 581-402. Eligibility to enter surrogacy agreement. (a) A person acting as surrogate shall be eligible to enter into an enforceable surrogacy agreement under this article if the person acting as surrogate has met the following requirements at the time the surrogacy agreement is executed:

(1) the person acting as surrogate is at least twenty-one years of age;

(2) the person acting as surrogate is a United States citizen or a lawful permanent resident and, where at least one intended parent is not a resident of New York state for six months, was a resident of New York state for at least six months;

(3) the person acting as surrogate has not provided the egg used to conceive the resulting child;

(4) the person acting as surrogate has completed a medical evaluation with a health care practitioner relating to the anticipated pregnancy. Such medical evaluation shall include a screening of the medical history of the potential surrogate including known health conditions that may pose risks to the potential surrogate or embryo during pregnancy;

(5) the person acting as surrogate has given informed consent for the surrogacy after the licensed health care practitioner inform them of the medical risks of surrogacy including the possibility of multiple births, risk of medications taken for the surrogacy, risk of pregnancy complications, psychological and psychosocial risks, and impacts on their personal lives;

(6) the person acting as surrogate, and the spouse of the person acting as surrogate, if applicable, have been represented throughout the contractual process and the duration of the contract and its execution by independent legal counsel of their own choosing who is licensed to practice law in the state of New York which shall be paid for by the intended parent or parents except that a person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents pay the fee for such legal counsel. Where the intended parent or parents are paying for the independent legal counsel of the person acting as surrogate, and the spouse of the person acting

as surrogate, if applicable, a separate retainer agreement shall be prepared clearly stating that such legal counsel will only represent the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, in all matters pertaining to the surrogacy agreement, that such legal counsel will not offer legal advice to any other parties to the surrogacy agreement, and that the attorney-client relationship lies with the person acting as surrogate and the spouse of the person acting as surrogate, if applicable;

(7) the person acting as surrogate has or the surrogacy agreement stipulates that the person acting as surrogate will obtain a comprehensive health insurance policy that takes effect prior to taking any medication or commencing treatment to further embryo transfer that covers preconception care, prenatal care, major medical treatments, hospitalization, and behavioral health care, and the comprehensive policy has a term that extends throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy; the policy shall be paid for, whether directly or through reimbursement or other means, by the intended parent or parents on behalf of the person acting as surrogate pursuant to the surrogacy agreement, except that a person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents pay for the health insurance policy. The intended parent or parents shall also pay for or reimburse the person acting as surrogate for all co-payments, deductibles and any other out-of-pocket medical costs associated with preconception, pregnancy, childbirth, or postnatal care, that accrue through twelve months after the birth of the child, a stillbirth, a miscarriage, or termination of the pregnancy. A person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents make such payments or reimbursements;

(8) the surrogacy agreement must provide that the intended parent or parents shall procure and pay for a life insurance policy for the person acting as surrogate that takes effect prior to taking any medication or the commencement of medical procedures to further embryo transfer, provides a minimum benefit of seven hundred fifty thousand dollars or the maximum amount the person acting as surrogate qualifies for if less than seven hundred fifty thousand dollars, and has a term that extends throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy, with a beneficiary or beneficiaries of their choosing. The policy shall be paid for, whether directly or through reimbursement or other means, by the intended parent or parents on behalf of the person acting as surrogate pursuant to the surrogacy agreement, except that a person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents pay for the life insurance policy; and

(9) the person acting as surrogate meets all other requirements deemed appropriate by the commissioner of health regarding the health of the prospective surrogate.

(b) The intended parent or parents shall be eligible to enter into an enforceable surrogacy agreement under this article if he, she or they have met the following requirements at the time the surrogacy agreement was executed:

(1) at least one intended parent is a United States citizen or a lawful permanent resident and was a resident of New York state for at least six months;

(2) the intended parent or parents has been represented throughout the contractual process and the duration of the contract and its execution by independent legal counsel of his, her or their own choosing who is licensed to practice law in the state of New York; and

(3) he or she is an adult person who is not in a spousal relationship, or adult spouses together, or any two adults who are intimate partners together, except an adult in a spousal relationship is eligible to enter into an enforceable surrogacy agreement without his or her spouse if:

(i) they are living separate and apart pursuant to a decree or judgment of separation or pursuant to a written agreement of separation subscribed by the parties thereto and acknowledged or proved in the form required to entitle a deed to be recorded; or

(ii) they have been living separate and apart for at least three years prior to execution of the surrogacy agreement.

(c) where the spouse of an intended parent is not a required party to the agreement, the spouse is not an intended parent and shall not have rights or obligations to the child.

§ 581-403. Requirements of surrogacy agreement. A surrogacy agreement shall be deemed to have satisfied the requirements of this article and be enforceable if it meets the following requirements:

(a) it shall be in a signed record verified or executed before two non-party witnesses by:

(1) each intended parent, and

(2) the person acting as surrogate, and the spouse of the person acting as surrogate, if any, unless:

(i) the person acting as surrogate and the spouse of the person acting as surrogate are living separate and apart pursuant to a decree or judgment of separation or pursuant to a written agreement of separation subscribed by the parties thereto and acknowledged or proved in the form required to entitle a deed to be recorded; or

(ii) have been living separate and apart for at least three years prior to execution of the surrogacy agreement;

(b) it shall be executed prior to the person acting as surrogate taking any medication or the commencement of medical procedures in the furtherance of embryo transfer, provided the person acting as surrogate shall have provided informed consent to undergo such medical treatment or medical procedures prior to executing the agreement;

(c) it shall be executed by a person acting as surrogate meeting the eligibility requirements of subdivision (a) of section 581-402 of this part and by the spouse of the person acting as surrogate, unless the signature of the spouse of the person acting as surrogate is not required as set forth in this section;

(d) it shall be executed by intended parent or parents who met the eligibility requirements of subdivision (b) of section 581-402 of this part;

(e) the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, and the intended parent or parents shall have been represented throughout the contractual process and the duration of the contract and its execution by separate, independent legal counsel of their own choosing;

(f) if the surrogacy agreement provides for the payment of compensation to the person acting as surrogate, the funds for base compensation and reasonable anticipated additional expenses shall have been placed in escrow with an independent escrow agent, who consents to the jurisdiction of New York courts for all proceedings related to the enforcement of the escrow agreement, prior to the person acting as surrogate commencing with any medical procedure other than medical evaluations necessary to determine the person acting as surrogate's eligibility;

(g) the surrogacy agreement must include information disclosing how the intended parent or parents will cover the medical expenses of the person acting as surrogate and the child. If comprehensive health care coverage is used to cover the medical expenses, the disclosure shall include a review and summary of the health care policy provisions related to coverage and exclusions for the person acting as surrogate's pregnancy; and

(h) it shall include the following information:

(1) the date, city and state where the surrogacy agreement was executed;

(2) the first and last names of and contact information for the intended parent or parents and of the person acting as surrogate;

(3) the first and last names of and contact information for the persons from which the gametes originated, if known. The agreement shall specify whether the gametes provided were eggs, sperm, or embryos;

(4) the name of and contact information for the licensed and registered surrogacy program handling the surrogacy agreement; and

(5) the name of and contact information for the attorney representing the person acting as surrogate, and the spouse of the person acting as surrogate, if applicable, and the attorney representing the intended parent or parents; and

(i) the surrogacy agreement must comply with all of the following terms:

(1) As to the person acting as surrogate and the spouse of the person acting as surrogate, if applicable:

(i) the person acting as surrogate agrees to undergo embryo transfer and attempt to carry and give birth to the child;

(ii) the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, agree to surrender custody of all resulting children to the intended parent or parents immediately upon birth;

(iii) the surrogacy agreement shall include the name of the attorney representing the person acting as surrogate and, if applicable, the spouse of the person acting as surrogate;

(iv) the surrogacy agreement must include an acknowledgement by the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, that they have received a copy of the Surrogate's Bill of Rights from their legal counsel;

(v) the surrogacy agreement must permit the person acting as surrogate to make all health and welfare decisions regarding themselves and their pregnancy including but not limited to, whether to consent to a cesarean section or multiple embryo transfer., and notwithstanding any other provisions in this chapter, provisions in the agreement to the contrary are void and unenforceable. This article does not diminish the right of the person acting as surrogate to terminate or continue a pregnancy;

(vi) the surrogacy agreement shall permit the person acting as a surrogate to utilize the services of a health care practitioner of the person's choosing;

(vii) the surrogacy agreement shall not limit the right of the person acting as surrogate to terminate or continue the pregnancy or reduce or retain the number of fetuses or embryos the person is carrying;

(viii) the surrogacy agreement shall provide for the right of the person acting as surrogate, upon request, to obtain counseling to address issues resulting from the person's participation in the surrogacy agreement, including, but not limited to, counseling following delivery. The cost of that counseling shall be paid by the intended parent or parents;

(ix) the surrogacy agreement must include a notice that any compensation received pursuant to the agreement may affect the person acting as surrogate's ability for public benefits or the amount of such benefits; and

(x) the surrogacy agreement shall provide that, upon the person acting as surrogate's request, the intended parent or parents have or will procure and pay for a disability insurance policy for the person acting as surrogate; the person acting as surrogate may designate the beneficiary of the person's choosing.

(2) As to the intended parent or parents:

(i) the intended parent or parents agree to accept custody of all resulting children immediately upon birth regardless of number, gender, or mental or physical condition and regardless of whether the intended embryos were transferred due to a laboratory error without diminishing the rights, if any, of anyone claiming to have a superior parental interest in the child; and

(ii) the intended parent or parents agree to assume responsibility for the support of all resulting children immediately upon birth; and

(iii) the surrogacy agreement shall include the name of the attorney representing the intended parent or parents; and

(iv) the surrogacy agreement shall provide that the rights and obligations of the intended parent or parents under the surrogacy agreement are not assignable; and

(v) the intended parent or parents agree to execute a will, prior to the embryo transfer, designating a guardian for all resulting children and authorizing their executor to perform the intended parent's or parents' obligations pursuant to the surrogacy agreement.

§ 581-404. Surrogacy agreement: effect of subsequent spousal relationship. (a) After the execution of a surrogacy agreement under this article, the subsequent spousal relationship of the person acting as surrogate does not affect the validity of a surrogacy agreement, the consent of the spouse of the person acting as surrogate to the agreement shall not be required, and the spouse of the person acting as surrogate shall not be the presumed parent of any resulting children.

(b) The subsequent separation or divorce of the intended parents does not affect the rights, duties and responsibilities of the intended parents as outlined in the surrogacy agreement. After the execution of a surrogacy agreement under this article, the subsequent spousal relationship of the intended parent does not affect the validity of a surrogacy agreement, and the consent of the spouse of the intended parent to the agreement shall not be required.

§ 581-405. Termination of surrogacy agreement. After the execution of a surrogacy agreement but before the person acting as surrogate becomes pregnant by means of assisted reproduction, the person acting as surrogate, the spouse of the person acting as surrogate, if applicable, or any intended parent may terminate the surrogacy agreement by giving notice of termination in a record to all other parties. Upon proper termination of the surrogacy agreement the parties are released from all obligations recited in the surrogacy agreement except that the intended parent or parents remains responsible for all expenses that are reimbursable under the agreement which have been incurred by the person acting as surrogate through the date of termination. If the intended parent or parents terminate the surrogacy agreement pursuant to this section after the person acting as surrogate has taken any medication or commenced treatment to further embryo transfer, such intended

parent or parents shall be responsible for paying for or reimbursing the person acting as surrogate for all co-payments, deductibles, any other out-of-pocket medical costs, and any other economic losses incurred within twelve months of the termination of the agreement and associated with taking such medication or undertaking such treatment. Unless the agreement provides otherwise, the person acting as surrogate is entitled to keep all payments received and obtain all payments to which the person is entitled up until the date of termination of the agreement. Neither a person acting as surrogate nor the spouse of the person acting as surrogate, if any, is liable to the intended parent or parents for terminating a surrogacy agreement as provided in this section.

§ 581-406. Parentage under compliant surrogacy agreement. Upon the birth of a child conceived by assisted reproduction under a surrogacy agreement that complies with this part, each intended parent is, by operation of law, a parent of the child and neither the person acting as a surrogate nor the person's spouse, if any, is a parent of the child.

§ 581-407. Insufficient surrogacy agreement. If a surrogacy agreement does not meet the material requirements of this article, the agreement is not enforceable and the court shall determine parentage based on the intent of the parties, taking into account the best interests of the child. An intended parent's absence of genetic connection to the child is not a sufficient basis to deny that individual a judgment of legal parentage.

§ 581-408. Absence of surrogacy agreement. Where there is no surrogacy agreement, the parentage of the child will be determined based on other laws of this state.

§ 581-409. Dispute as to surrogacy agreement. (a) Any dispute which is related to a surrogacy agreement other than disputes as to parentage shall be resolved by the supreme court, which shall determine the respective rights and obligations of the parties, in any proceeding initiated pursuant to this section, the court may, at its discretion, authorize the use of conferencing or mediation at any point in the proceedings.

(b) Except as expressly provided in the surrogacy agreement, the intended parent or parents and the person acting as surrogate shall be entitled to all remedies available at law or equity in any dispute related to the surrogacy agreement.

(c) There shall be no specific performance remedy available for a breach.

PART 5

PAYMENT TO DONORS AND PERSONS ACTING AS SURROGATES Section 581-501. Reimbursement.

581-502. Compensation.

§ 581-501. Reimbursement. A donor who has entered into a valid agreement to be a donor may receive reimbursement from an intended parent or parents for economic losses

incurred in connection with the donation which result from the retrieval or storage of gametes or embryos.

§ 581-502. Compensation. (a) Compensation may be paid to a donor or person acting as surrogate based on medical risks, physical discomfort, inconvenience and the responsibilities they are undertaking in connection with their participation in the assisted reproduction. Under no circumstances may compensation be paid to purchase gametes or embryos or for the release of a parental interest in a child.

(b) The compensation, if any, paid to a donor or person acting as surrogate must be reasonable and negotiated in good faith between the parties, and said payments to a person acting as surrogate shall not exceed the duration of the pregnancy and recuperative period of up to eight weeks after the birth of any resulting children.

(c) Compensation may not be conditioned upon the purported quality or genome-related traits of the gametes or embryos.

(d) Compensation may not be conditioned on actual genotypic or phenotypic characteristics of the donor or of any resulting children.

(e) Compensation to an embryo donor shall be limited to storage fees, transportation costs and attorneys' fees.

PART 6

SURROGATES' BILL OF RIGHTS Section 581-601. Applicability.

581-602. Health and welfare decisions.

581-603. Independent legal counsel.

581-604. Health insurance and medical costs.

581-605. Counseling.

581-606. Life insurance.

581-607. Termination of surrogacy agreement.

§ 581-601. Applicability. The rights enumerated in this part shall apply to any person acting as surrogate in this state, notwithstanding any surrogacy agreement, judgment of parentage, memorandum of understanding, verbal agreement or contract to the contrary. Except as otherwise provided by law, any written or verbal agreement purporting to waive or limit any of the rights in this part is void as against public policy. The rights enumerated in this part are not exclusive, and are in addition to any other rights provided by law, regulation, or a surrogacy agreement that meets the requirements of this article.

§ 581-602. Health and welfare decisions. A person acting as surrogate has the right to make all health and welfare decisions regarding them-self and their pregnancy, including but not limited to whether to consent to a cesarean section or multiple embryo transfer, to utilize the services of a health care practitioner of their choosing, whether to terminate or continue the pregnancy, and whether to reduce or retain the number of fetuses or embryos they are carrying.

§ 581-603. Independent legal counsel. A person acting as surrogate has the right to be represented throughout the contractual process and the duration of the surrogacy agreement and its execution by independent legal counsel of their own choosing who is licensed to practice law in the state of New York, to be paid for by the intended parent or parents.

§ 581-604. Health insurance and medical costs. A person acting as surrogate has the right to have a comprehensive health insurance policy that covers preconception care, prenatal care, major medical treatments, hospitalization and behavioral health care for a term that extends throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy, to be paid for by the intended parent or parents. The intended parent or parents shall also pay for or reimburse the person acting as surrogate for all co-payments, deductibles and any other out-of-pocket medical costs associated with pregnancy, childbirth, or postnatal care that accrue through twelve months after the birth of the child, a stillbirth, a miscarriage, or the termination of the pregnancy. A person acting as a surrogate who is receiving no compensation may waive the right to have the intended parent or parents make such payments or reimbursements.

§ 581-605. Counseling. A person acting as surrogate has the right to obtain a comprehensive health insurance policy that covers behavioral health care and will cover the cost of psychological counseling to address issues resulting from their participation in a surrogacy and such policy shall be paid for by the intended parent or parents.

§ 581-606. Life insurance. A person acting as surrogate has the right to be provided a life insurance policy that takes effect prior to taking any medication or commencement of treatment to further embryo transfer, provides a minimum benefit of seven hundred fifty thousand dollars, or the maximum amount the person acting as surrogate qualifying for it less than seven hundred fifty thousand dollars, and has a term that extends throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy, with a beneficiary or beneficiaries of their choosing, to be paid for by the intended parent or parents.

§ 581-607. Termination of surrogacy agreement. A person acting as surrogate has the right to terminate a surrogacy agreement prior to becoming pregnant by means of assisted reproduction pursuant to section 581-405 of this article.

PART 7

MISCELLANEOUS PROVISIONS Section 581-701. Remedial.

581-702. Severability.

581-703. Parent under section seventy of the domestic relations

law.

581-704. Interpretation.

§ 581-701. Remedial. This legislation is hereby declared to be a remedial statute and is to be construed liberally to secure the beneficial interests and purposes thereof for the best interests of the child.

§ 581-702. Severability. The invalidation of any part of this legislation by a court of competent jurisdiction shall not result in the invalidation of any other part.

§ 581-703. Parent under section seventy of the domestic relations law. The term "parent" in section seventy of the domestic relations law shall include a person established to be a parent under this article or any other relevant law.

§ 581-704. Interpretation. Unless the context indicates otherwise, words importing the singular include and apply to several persons, parties, or things; words importing the plural include the singular.

§ 2. Section 73 of the domestic relations law is REPEALED.

§ 3. Section 121 of the domestic relations law, as added by chapter 308 of the laws of 1992, is amended to read as follows:

§ 121. Definitions. When used in this article, unless the context or subject matter manifestly requires a different interpretation:

1.[~~**"Birth mother"**~~] **"Genetic surrogate"** shall mean a [~~**woman**~~] **person** who gives birth to a child **who is the person's genetic child** pursuant to a **genetic** surrogate parenting [~~**contract**~~] **agreement**.

2. [~~**"Genetic father" shall mean a man who provides sperm for the birth of a child born pursuant to a surrogate parenting contract.**~~

~~**3. "Genetic mother" shall mean a woman who provides an ovum for the birth of a child born pursuant to a surrogate parenting contract.**~~

~~**4. "Surrogate parenting contract"**~~] **"Genetic surrogate parenting agreement"** shall mean any agreement, oral or written, in which:

(a) a [~~woman~~] **genetic surrogate** agrees either to be inseminated with the sperm of a [~~man~~] **person** who is not [~~her husband~~] **their spouse** or to be impregnated with an embryo that is the product of [~~an~~] **the genetic surrogate's** ovum fertilized with the sperm of a [~~man~~] **person** who is not [~~her husband~~] **their spouse**; and

(b) the [~~woman~~] **genetic surrogate** agrees to, or intends to, surrender or consent to the adoption of the child born as a result of such insemination or impregnation.

§ 4. Section 122 of the domestic relations law, as added by chapter 308 of the laws of 1992, is amended to read as follows:

§ 122. Public policy. [~~Surrogate~~] **Genetic surrogate** parenting [~~contracts~~] **agreements** are hereby declared contrary to the public policy of this state, and are void and unenforceable.

§ 5. Section 123 of the domestic relations law, as added by chapter 308 of the laws of 1992, is amended to read as follows:

§ 123. Prohibitions and penalties. 1. No person or other entity shall knowingly request, accept, receive, pay or give any fee, compensation or other remuneration, directly or indirectly, in connection with any **genetic** surrogate parenting [~~contract~~] **agreement**, or induce, arrange or otherwise assist in arranging a **genetic** surrogate parenting [~~contract~~] **agreement** for a fee, compensation or other remuneration, except for:

(a) payments in connection with the adoption of a child permitted by subdivision six of section three hundred seventy-four of the social services law and disclosed pursuant to subdivision eight of section one hundred fifteen of this chapter; or

(b) payments for reasonable and actual medical fees and hospital expenses for artificial insemination or in vitro fertilization services incurred by the [~~mother~~] **genetic surrogate** in connection with the birth of the child.

2. (a) [~~A birth mother or her husband, a genetic father and his wife, and, if the genetic mother is not the birth mother, the genetic mother and her husband~~] **Any party to a genetic surrogate parenting agreement or the spouse of any part to a genetic surrogate parenting agreement** who violate this section shall be subject to a civil penalty not to exceed five hundred dollars.

(b) Any other person or entity who or which induces, arranges or otherwise assists in the formation of a **genetic** surrogate parenting contract for a fee, compensation or other remuneration or otherwise violates this section shall be subject to a civil penalty not to exceed ten thousand dollars and forfeiture to the state of any such fee, compensation or remuneration in accordance with the provisions of subdivision (a) of section seven thousand two hundred one of the civil practice law and rules, for the first such offense. Any person or entity who or which induces, arranges or otherwise assists in the formation of a **genetic** surrogate parenting contract for a fee, compensation or other remuneration or otherwise violates this section, after having been once subject to a civil penalty for violating this section, shall be guilty of a felony.

§ 6. Section 124 of the domestic relations law, as added by chapter 308 of the laws of 1992, is amended to read as follows:

§ 124. Proceedings regarding parental rights, status or obligations. In any action or proceeding involving a [~~dispute between the birth mother and (i) the genetic father, (ii) the genetic mother, (iii) both the genetic father and genetic mother, or (iv) the parent or parents of the genetic father or genetic mother, regarding parental rights, status or obligations with respect to a child born pursuant to a surrogate parenting contract~~] **purported genetic surrogacy parenting agreement, the parentage of the child will be determined based on the laws of New York state and**:

1. the court shall not consider the [~~birth mother's~~] **genetic surrogate's** participation in a **genetic** surrogate parenting [~~contract~~] **agreement** as adverse to [~~her~~] **their** parental rights, status, or obligations; and

2. the court, having regard to the circumstances of the case and of the respective parties including the parties' relative ability to pay such fees and expenses, in its discretion and in the interests of justice, may award to either party reasonable and actual counsel fees and legal expenses incurred in connection with such action or proceeding. Such award may be made in the order or judgment by which the particular action or proceeding is finally determined, or by one or more orders from time to time before the final order or judgment, or by both such order or orders and the final order or judgment; provided, however, that in any dispute involving a [~~birth mother~~] **genetic surrogate** who has executed a valid surrender or consent to the adoption, nothing in this section shall empower a court to make any award that it would not otherwise be empowered to direct.

§ 7. Section 4135 of the public health law, subdivision 1 as amended by chapter 201 of the laws of 1972, subdivision 2 as amended by chapter 398 of the laws of 1997 and subdivision 3 as added by chapter 342 of the laws of 1980, is amended to read as follows:

§ 4135. Birth certificate; child born out of wedlock. 1. (a) There shall be no specific statement on the birth certificate as to whether the child is born in wedlock or out of wedlock or as to the marital name or status of the mother.

(b) The phrase "child born out of wedlock" when used in this article, refers to a child whose father is not its mother's husband.

2. The name of the [~~putative~~] **alleged** father of a child born out of wedlock shall not be entered on the certificate of birth prior to filing without (i) an acknowledgment of [~~paternity~~] **parentage** pursuant to section one hundred eleven-k of the social services law or section four thousand one hundred thirty-five-b of this article executed by both the mother and [~~putative~~] **alleged** father, and filed with the record of birth; or (ii) notification having been received by, or proper proof having been filed with, the record of birth by the clerk of a court of competent jurisdiction or the parents, or their attorneys of a judgment, order or decree relating to parentage.

3. Orders relating to parentage shall be held confidential by the commissioner and shall not be released or otherwise divulged except by order of a court of competent jurisdiction.

§ 8. Section 4135-b of the public health law, as added by chapter 59 of the laws of 1993, subdivisions 1 and 2 as amended by chapter 402 of the laws of 2013, and subdivision 3 as amended by chapter 170 of the laws of 1994, is amended to read as follows:

§ 4135-b. Voluntary acknowledgments of [~~paternity; child born out of wedlock~~] **parentage**. 1. (a) Immediately preceding or following the in-hospital birth of a child to an unmarried [~~woman~~] **person or to a person who gave birth to a child conceived through assisted reproduction**, the person in charge of such hospital or his or her designated representative shall provide to the [~~child's mother and putative father~~] **unmarried person who gave birth to the child and the alleged genetic parent**, if such [~~father~~] **alleged genetic parent is readily identifiable and available, or to the person who gave birth and the other intended parent of a child conceived through assisted reproduction if such person** is readily identifiable and available, the documents and written instructions necessary for such [~~mother~~] **person or to a person who gave birth to a child conceived through assisted reproduction** and [~~putative father~~] **alleged persons** to complete an acknowledgment of [~~paternity~~] **parentage** witnessed by two persons not related to the signatory. Such acknowledgment, if signed by both parties, at any time following the birth of a child, shall be filed with the registrar at the same time at which the certificate of live birth is filed, if possible, or anytime thereafter. Nothing herein shall be deemed to require the person in charge of such hospital or his or her designee to seek out or otherwise locate [~~a putative father~~] **an alleged genetic parent or intended parent of a child conceived through assisted reproduction** who is not readily identifiable or available.

(b) The following persons may sign an acknowledgment of parentage to establish the parentage of the child:

(i) An unmarried person who gave birth to the child and another person who is a genetic parent.

(ii) A married or unmarried person who gave birth to the child and another person who is an intended parent under section 581-303 of the family court act of a child conceived through assisted reproduction.

(c) An acknowledgment of parentage shall be in a record signed by the person who gave birth to the child and by either the genetic parent other than the person who gave birth to the child or a person who is a parent under section 581-303 of the family court act of the child conceived through assisted reproduction.

(d) An acknowledgment of parentage is void if, at the time of signing, any of the following are true:

(i) A person other than the signatories is a presumed parent of the child under section twenty-four of the domestic relations law;

(ii) A court has entered a judgment of parentage of the child;

(iii) Another person has signed a valid acknowledgment of parentage with regard to the child;

(iv) The child has a parent under section 581-303 of the family court act other than the signatories;

(v) A signatory is a gamete donor under section 581-302 of the family court act;

(vi) The acknowledgment is signed by a person who asserts that they are a parent under section 581-303 of the family court act of a child conceived through assisted reproduction, but the child was not conceived through assisted reproduction.

(e) The acknowledgment shall be executed on a form provided by the commissioner developed in consultation with the [~~appropriate~~] commissioner of the [~~department of family assistance~~] **office of temporary and disability assistance**, which shall**: (i)** include the social security number of the [~~mother and of the putative father and~~] **signatories; (ii)** provide in plain language [~~(i)~~] **(A)** a statement by the [~~mother~~] **person who gave birth to the child** consenting to the acknowledgment of [~~paternity~~] **parentage** and a statement that the [~~putative father~~] **other signatory** is the only possible [~~father~~] **other genetic parent or that the other signatory is an intended parent and the child was conceived through assisted reproduction**, [~~(ii)~~] **(B)** a statement by the [~~putative father~~]**, alleged genetic parent, if any,** that he **or she** is the [~~biological father~~] **genetic parent** of the child, and [~~(iii)~~] **(C)** a statement that the signing of the acknowledgment of [~~paternity~~] **parentage** by both parties shall have the same force and effect as an order of **parentage or** filiation entered after a court hearing by a court of competent jurisdiction, including an obligation to provide support for the child except that, only if filed with the registrar of the district in which the birth certificate has been filed, will the acknowledgment have such force and effect with respect to inheritance rights**; and (iii) include the name and address, if known, of any gamete donors**.

[~~(b)~~] **(f)** Prior to the execution of an acknowledgment of [~~paternity~~] **parentage**, the [~~mother~~] **person who gave birth to the child** and the [~~putative father~~] **other signatory** shall be provided orally, which may be through the use of audio or video equipment, and in writing with such information as is required pursuant to this section with respect to their rights and the consequences of signing a voluntary acknowledgment of [~~paternity~~] **parentage** including, but not limited to:

(i) that the signing of the acknowledgment of [~~paternity~~] **parentage** shall establish the [~~paternity~~] **parentage** of the child and shall have the same force and effect as an order of [~~paternity~~] **parentage** or filiation issued by a court of competent jurisdiction establishing the duty of both parties to provide support for the child;

(ii) that if such an acknowledgment is not made, the [~~putative father~~] **signatory other than the person who gave birth to the child** can be held liable for support only if the family court, after a hearing, makes an order declaring that the [~~putative father~~] **person** is the

[~~father~~] **parent** of the child whereupon the court may make an order of support which may be retroactive to the birth of the child;

(iii) that if made a respondent in a proceeding to establish [~~paternity~~] **parentage** the [~~putative father~~] **signatory other than the person who gave birth to the child** has a right to free legal representation if indigent;

(iv) that [~~the putative father~~] **an alleged genetic parent** has a right to a genetic marker test or to a DNA test when available;

(v) that by executing the acknowledgment, the [~~putative father~~] **alleged genetic parent** waives [~~his~~] **their** right to a hearing, to which [~~he~~] **they** would otherwise be entitled, on the issue of [~~paternity~~] **parentage**;

(vi) that a copy of the acknowledgment of [~~paternity~~] **parentage** shall be filed with the [~~putative father~~] registry [~~pursuant to~~] **created by** section three hundred seventy-two-c of the social services law, and that such filing may establish the child's right to inheritance from the [~~putative father~~] **alleged genetic parent or the other intended parent of a child conceived through assisted reproduction** pursuant to clause (B) of subparagraph two of paragraph (a) of section 4-1.2 of the estates, powers and trusts law;

(vii) that, if such acknowledgment is filed with the registrar of the district in which the birth certificate has been filed, such acknowledgment will establish inheritance rights from the [~~putative father~~] **alleged genetic parent or the other intended parent of a child conceived through assisted reproduction** pursuant to clause (A) of subparagraph two of paragraph (a) of section 4-1.2 of the estates, powers and trusts law;

(viii) that no further judicial or administrative proceedings are required to ratify an unchallenged acknowledgment of [~~paternity~~] **parentage** provided, however, that:

(A) A signatory to an acknowledgment of [~~paternity~~] **parentage**, who had attained the age of eighteen at the time of execution of the acknowledgment, shall have the right to rescind the acknowledgment within the earlier of sixty days from the date of signing the acknowledgment or the date of an administrative or a judicial proceeding (including, but not limited to, a proceeding to establish a support order) relating to the child in which the signatory is a party, provided that the "date of an administrative or a judicial proceeding" shall be the date by which the respondent is required to answer the petition;

(B) A signatory to an acknowledgment of [~~paternity~~] **parentage**, who had not attained the age of eighteen at the time of execution of the acknowledgment, shall have the right to rescind the acknowledgment anytime up to sixty days after the signatory's attaining the age of eighteen years or sixty days after the date on which the respondent is required to answer a petition (including, but not limited to, a petition to establish a support order) relating to the child, whichever is earlier; provided, however, that the signatory must have been advised at such proceeding of his or her right to file a petition to vacate the acknowledgment within sixty days of the date of such proceeding;

(ix) that after the expiration of the time limits set forth in clauses (A) and (B) of subparagraph (viii) of this paragraph, any of the signatories may challenge the acknowledgment of [~~paternity~~] **parentage** in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof on the party challenging the voluntary acknowledgment;

(x) that the [~~putative father and mother~~] **person who gave birth to the child and the other signatory** may wish to consult with attorneys before executing the acknowledgment; and that they have the right to seek legal representation and supportive services including counseling regarding such acknowledgment;

(xi) that the acknowledgment of [~~paternity~~] **parentage** may be the basis for the [~~putative father~~] **signatory other than the person who gave birth to the child** establishing custody and visitation rights to the child and for requiring the [~~putative father's~~] consent **of the signatory other than the person who gave birth to the child** prior to an adoption proceeding;

(xii) that the [~~mother's~~] refusal **of the person who gave birth to the child** to sign the acknowledgment shall not be deemed a failure to cooperate in establishing [~~paternity for~~] **parentage of** the child; and

(xiii) that the child may bear the last name of either parent, **or any combination thereof,** which name shall not affect the legal status of the child. In addition, the governing body of such hospital shall [~~insure~~] **ensure** that appropriate staff shall provide to the [~~child's mother and putative father~~] **person who gave birth to the child and the other signatory**, prior to the [~~mother's~~] discharge from the hospital **of the person who gave birth to the child**, the opportunity to speak with hospital staff to obtain clarifying information and answers to their questions about [~~paternity~~] **parentage** establishment, and shall also provide the telephone number of the local support collection unit.

[~~(c)~~] **(g)** Within ten days after receiving the certificate of birth, the registrar shall furnish without charge to each parent or guardian of the child or to the [~~mother~~] **person who gave birth** at the address designated by her for that purpose, a certified copy of the certificate of birth and, if applicable, a certified copy of the written acknowledgment of [~~paternity~~] **parentage**. If the [~~mother~~] **person who gave birth** is in receipt of child support enforcement services pursuant to title six-A of article three of the social services law, the registrar also shall furnish without charge a certified copy of the certificate of birth and, if applicable, a certified copy of the written acknowledgment of [~~paternity~~] **parentage** to the social services district of the county within which the [~~mother~~] **person who gave birth** resides.

2. (a) When a child's [~~paternity~~] **parentage** is acknowledged voluntarily pursuant to section one hundred eleven-k of the social services law, the social services official shall file the executed acknowledgment with the registrar of the district in which the birth occurred and in which the birth certificate has been filed.

(b) Where a child's [~~paternity~~] **parentage** has not been acknowledged voluntarily pursuant to paragraph (a) of subdivision one of this section or paragraph (a) of this subdivision, the [~~child's mother and the putative father~~] **person who gave birth to the child and the**

other signatory may voluntarily acknowledge a child's [~~**paternity**~~] **parentage** pursuant to this paragraph by signing the acknowledgment of [~~**paternity**~~] **parentage**.

(c) A signatory to an acknowledgment of [~~**paternity**~~] **parentage**, who has attained the age of eighteen at the time of execution of the acknowledgment shall have the right to rescind the acknowledgment within the earlier of sixty days from the date of signing the acknowledgment or the date of an administrative or a judicial proceeding (including, but not limited to, a proceeding to establish a support order) relating to the child in which either signatory is a party; provided that for purposes of this section, the "date of an administrative or a judicial proceeding" shall be the date by which the respondent is required to answer the petition.

(d) A signatory to an acknowledgment of [~~**paternity**~~] **parentage**, who has not attained the age of eighteen at the time of execution of the acknowledgment, shall have the right to rescind the acknowledgment anytime up to sixty days after the signatory's attaining the age of eighteen years or sixty days after the date on which the respondent is required to answer a petition (including, but not limited to, a petition to establish a support order) relating to the child in which the signatory is a party, whichever is earlier; provided, however, that the signatory must have been advised at such proceeding of his or her right to file a petition to vacate the acknowledgment within sixty days of the date of such proceeding.

(e) After the expiration of the time limits set forth in paragraphs (c) and (d) of this subdivision, any of the signatories may challenge the acknowledgment of [~~**paternity**~~] **parentage** in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof on the party challenging the voluntary acknowledgment. The acknowledgment shall have full force and effect once so signed. The original or a copy of the acknowledgment shall be filed with the registrar of the district in which the birth certificate has been filed.

3. (a) An acknowledgment of [~~**paternity**~~] **parentage** executed by [~~**the mother and father of a child born out of wedlock**~~] **any two people eligible to sign such an acknowledgment under paragraph (b) of subdivision one of this section, married or unmarried,** shall establish the [~~**paternity**~~] **parentage** of a child and shall have the same force and effect as an order of [~~**paternity**~~] **parentage** or filiation issued by a court of competent jurisdiction. Such acknowledgement shall thereafter be filed with the registrar pursuant to subdivision one or two of this section.

(b) A registrar with whom an acknowledgment of [~~**paternity**~~] **parentage** has been filed pursuant to subdivision one or two of this section shall file the acknowledgment with the state department of health [~~**and the putative father registry**~~]**, the New York city department of health and mental hygiene and the registry operated by the department of social services pursuant to section three hundred seventy-two-c of the social services law. If the acknowledgment includes the name and address of any known gamete donors of a child conceived through assisted reproduction, the state department of health or the New York city department of health and mental hygiene shall mail a copy to the known donors listed on the form with the social security numbers of the signatories redacted**.

4. **The court shall give full faith and credit to an acknowledgment of parentage effective in another state if the acknowledgment was in a signed record and otherwise complies with the law of the other state.**

5. A new certificate of birth shall be issued if the certificate of birth of [~~a~~] **the** child [~~born out of wedlock~~] as defined in paragraph (b) of subdivision one of section four thousand one hundred thirty-five of this article has been filed without entry of the name of the [~~father~~] **signatory other than the person who gave birth**, and the commissioner thereafter receives a notarized acknowledgment of [~~paternity~~] **parentage** accompanied by the written consent of the [~~putative father and mother~~] **person who gave birth to the child and other signatory** to the entry of the name of such [~~father~~] **person**, which consent may also be to a change in the surname of the child.

6. Any reference to an acknowledgment of paternity in any law of this state shall be interpreted to mean an acknowledgment of parentage signed pursuant to this section or signed in another state consistent with the law of that state.

§ 9. Paragraph (e) of subdivision 1 of section 4138 of the public health law, as amended by chapter 214 of the laws of 1998, is amended to read as follows:

(e) the certificate of birth of a child born out of wedlock as defined in paragraph (b) of subdivision one of section four thousand one hundred thirty-five of this article has been filed without entry of the name of the [~~father~~] **signatory other than the person who gave birth** and the commissioner thereafter receives the acknowledgment of [~~paternity~~] **parentage** pursuant to section one hundred eleven-k of the social services law or section four thousand one hundred thirty-five-b of this article executed by the [~~putative father and mother~~] **person who gave birth and the other signatory** which authorizes the entry of the name of such [~~father~~] **other signatory**, and which may also authorize a conforming change in the surname of the child.

§ 10. The article heading of article 8 of the domestic relations law, as added by chapter 308 of the laws of 1992, is amended to read as follows:

GENETIC SURROGATE PARENTING CONTRACTS

§ 11. The general business law is amended by adding a new article 44 to read as follows:

ARTICLE 44

REGULATION OF SURROGACY PROGRAMS AND ASSISTED

REPRODUCTION SERVICE PROVIDERS Section 1400. Definitions.

1401. Surrogacy programs regulated under this article.

1402. Assisted reproduction service providers regulated under

this article.

1403. Conflicts of interest; prohibition on payments; funds in

escrow; licensure; notice of surrogates' bill of rights.

1404. Regulations.

§ 1400. Definitions. As used in this section:

(a) The definitions in section 581-102 of the family court act shall apply.

(b) "Payment" means any type of monetary compensation or other valuable consideration including but not limited to a rebate, refund, commission, unearned discount, or profit by means of credit or other valuable consideration.

(c) "Surrogacy program" does not include any party to a surrogacy agreement or any person licensed to practice law and representing a party to the surrogacy agreement, but does include and is not limited to any agency, agent, business, or individual engaged in, arranging, or facilitating transactions contemplated by a surrogacy agreement, regardless of whether such agreement ultimately comports with the requirements of article five-C of the family court act.

§ 1401. Surrogacy programs regulated under this article. The provisions of this article apply to surrogacy programs arranging or facilitating transactions contemplated by a surrogacy agreement under part four of article five-C of the family court act if:

(a) The surrogacy program does business in New York state;

(b) A person acting as surrogate who is party to a surrogacy agreement resides in New York state during the term of the surrogacy agreement; or

(c) Any medical procedures under the surrogacy agreement are performed in New York state.

§ 1402. Assisted reproduction service providers regulated under this article. The provisions of this article apply to agents, gamete banks, fertility clinics, and other entities if:

1. The agent, gamete bank, fertility clinic, or other entity does business in this state; or

2. Any health care services performed, provided or otherwise arranged by the entity are performed in this state.

§ 1403. Conflicts of interest; prohibition on payments; funds in escrow; licensure; notice of surrogates' bill of rights. A surrogacy program to which this article applies:

(a) Shall keep all funds paid by or on behalf of the intended parent or parents in an escrow account separate from its operating accounts; and

(b) May not be owned or managed, in any part, directly or indirectly, by any attorney representing a party to the surrogacy agreement; and

(c) May not pay or receive payment, directly or indirectly, to or from any person licensed to practice law and representing a party to the surrogacy agreement in connection with the referral of any person or party for the purpose of a surrogacy agreement; and

(d) May not pay or receive payment, directly or indirectly, to or from any health care provider providing any health services, including assisted reproduction, to a party to the surrogacy agreement; and

(e) May not be owned or managed, in any part, directly or indirectly, by any health care provider providing any health services, including assisted reproduction, to a party to the surrogacy agreement; and

(f) Shall be licensed to operate in New York state pursuant to regulations promulgated by the department of health in consultation with the department of financial services, once such regulations are promulgated and become effective; and

(g) Shall ensure that all potential parties to a surrogacy agreement, at the time of consultation with such surrogacy program, are provided with written notice of the surrogates' bill of rights enumerated in part six of article five-C of the family court act.

§ 1404. Regulations. 1. The department of health, in consultation with the department of financial services, shall promulgate rules and regulations to implement the requirements of this article regarding surrogacy programs and assisted reproduction service providers in a manner that ensures the safety and health of gamete providers and persons serving as surrogates. Such regulations shall:

(a) Require surrogacy programs to monitor compliance with surrogacy agreements eligibility and requirements in state law; and

(b) Require the surrogacy programs and assisted reproduction service providers to administer informed consent procedures that comply with regulations promulgated by the department of health under section twenty-five hundred ninety-nine-cc of the public health law.

2. The department of health shall annually report to the legislature regarding the practices of surrogacy programs and assisted reproduction service providers and all business transactions related to surrogacy and gamete provision in New York state, with recommendations for any necessary amendments to this article.

§ 12. The public health law is amended by adding a new article 25-B to read as follows:

ARTICLE 25-B

GESTATIONAL SURROGACY Section 2599-cc. Gestational surrogacy.

§ 2599-cc. Gestational surrogacy. 1. The commissioner shall promulgate regulations on the practice of gestational surrogacy. Such regulations shall include, but not be limited to:

(a) guidelines and procedures for obtaining fully informed consent from potential persons acting as surrogates, including but not limited to a full disclosure of any known or potential health risks and mental health impacts associated with acting as a surrogate;

(b) the development and distribution, in printed form and on the department's website, of informational material relating to gestational surrogacy;

(c) the establishment of a voluntary central tracking registry of persons acting as surrogates, as reported by surrogacy programs licensed by the department pursuant to article forty-four of the general business law upon the affirmative consent of a person acting as surrogate. Such registry shall provide a means for gathering and maintaining accurate information on the:

(i) number of times a person has acted as a surrogate;

(ii) health information of the person acting as surrogate; and

(iii) other information deemed appropriate by the commissioner;

(d) the development of guidelines, procedures or protocols, in consultation with the American college of obstetricians and gynecologists and the American society for reproductive medicine, to assist physicians in screening potential surrogates for their ability to serve as a surrogate as required under subdivision four of section 581-402 of the family court act including taking into consideration the potential surrogates family medical history and complications from prior pregnancies and known health conditions that may pose a risk to the potential surrogate during pregnancy; and

(e) the development of guidance to reduce conflicts of interest among physicians providing health care services to the surrogate.

2. All such regulations shall maintain the anonymity of the person acting as surrogate and any resulting offspring and govern access to information maintained by the registry. Such registry shall comply with all state and federal laws and regulations related to maintaining the privacy and confidentiality of records contained with the registry.

§ 13. Subdivisions 4, 5, 6, 7 and 8 of section 4365 of the public health law are renumbered subdivisions 5, 6, 7, 8 and 9 and a new subdivision 4 is added to read as follows:

4. The commissioner, in consultation with the transplant council, shall promulgate regulations on the donation of ova. Such regulations shall include, but not be limited to:

(a) guidelines and procedures for obtaining fully informed consent from potential donors, including but not limited to a full disclosure of any known or potential health risks of the ova donation process;

(b) the development and distribution, in printed form and on the department's website, of informational material relating to the donation of ova;

(c) the establishment of a voluntary central tracking registry of ova donor information, as reported by banks and storage facilities licensed pursuant to this article upon the affirmative consent of an ova donor. Such registry shall provide a means for gathering and maintaining accurate information on the:

(i) number of ova and the number of times ova have been donated from a single donor;

(ii) health information of the donor at the time of the donation; and

(iii) other information deemed appropriate by the commissioner.

In addition, all such regulations shall maintain the anonymity of the donor and any resulting offspring and govern access to information maintained by the registry. Such registry shall comply with all state and federal laws and regulations related to maintaining the privacy and confidentiality of records contained within the registry; and

(d) the development of best practices and procedures, in consultation with the American college of obstetricians and gynecologists, American society for reproductive medicine and other medical organizations, for ova donation, ova retrieval, and in vitro fertilization for the protection of the health and safety of the donor.

§ 14. Paragraph (a) of subdivision 1 of section 440 of the family court act, as amended by chapter 398 of the laws of 1997, is amended to read as follows:

(a) Any support order made by the court in any proceeding under the provisions of article five-B of this act, pursuant to a reference from the supreme court under section two hundred fifty-one of the domestic relations law or under the provisions of article four, five or five-A of this act (i) shall direct that payments of child support or combined child and spousal support collected on behalf of persons in receipt of services pursuant to section one hundred eleven-g of the social services law, or on behalf of persons in receipt of public assistance be made to the support collection unit designated by the appropriate social services district, which shall receive and disburse funds so paid; or (ii) shall be enforced pursuant to subdivision (c) of section five thousand two hundred forty-two of the civil practice law and rules at the same time that the court issues an order of support; and (iii) shall in either case, except as provided for herein, be effective as of the earlier of the date of the filing of the petition therefor, or, if the children for whom support is sought are in receipt of public assistance, the date for which their eligibility for

public assistance was effective. Any retroactive amount of support due shall be support arrears/past due support and shall be paid in one sum or periodic sums, as the court directs, and any amount of temporary support which has been paid to be taken into account in calculating any amount of such retroactive support due. In addition, such retroactive child support shall be enforceable in any manner provided by law including, but not limited to, an execution for support enforcement pursuant to subdivision (b) of section fifty-two hundred forty-one of the civil practice law and rules. When a child receiving support is a public assistance recipient, or the order of support is being enforced or is to be enforced pursuant to section one hundred eleven-g of the social services law, the court shall establish the amount of retroactive child support and notify the parties that such amount shall be enforced by the support collection unit pursuant to an execution for support enforcement as provided for in subdivision (b) of section fifty-two hundred forty-one of the civil practice law and rules, or in such periodic payments as would have been authorized had such an execution been issued. In such case, the court shall not direct the schedule of repayment of retroactive support. Where such direction is for child support and [~~paternity~~] **parentage** has been established by a voluntary acknowledgment of [~~paternity~~] **parentage** as defined in section forty-one hundred thirty-five-b of the public health law, the court shall inquire of the parties whether the acknowledgment has been duly filed, and unless satisfied that it has been so filed shall require the clerk of the court to file such acknowledgment with the appropriate registrar within five business days. The court shall not direct that support payments be made to the support collection unit unless the child, who is the subject of the order, is in receipt of public assistance or child support services pursuant to section one hundred eleven-g of the social services law. Any such order shall be enforceable pursuant to section fifty-two hundred forty-one or fifty-two hundred forty-two of the civil practice law and rules, or in any other manner provided by law. Such orders or judgments for child support and maintenance shall also be enforceable pursuant to article fifty-two of the civil practice law and rules upon a debtor's default as such term is defined in paragraph seven of subdivision (a) of section fifty-two hundred forty-one of the civil practice law and rules. The establishment of a default shall be subject to the procedures established for the determination of a mistake of fact for income executions pursuant to subdivision (e) of section fifty-two hundred forty-one of the civil practice law and rules. For the purposes of enforcement of child support orders or combined spousal and child support orders pursuant to section five thousand two hundred forty-one of the civil practice law and rules, a "default" shall be deemed to include amounts arising from retroactive support. Where permitted under federal law and where the record of the proceedings contains such information, such order shall include on its face the social security number and the name and address of the employer, if any, of the person chargeable with support provided, however, that failure to comply with this requirement shall not invalidate such order.

§ 15. Section 516-a of the family court act, as amended by chapter 398 of the laws of 1997, subdivisions (b) and (c) as amended by chapter 402 of the laws of 2013, and subdivision (d) as amended by chapter 343 of the laws of 2009, is amended to read as follows:

§ 516-a. Acknowledgment of [~~paternity~~] **parentage**. (a) An acknowledgment of [~~paternity~~] **parentage** executed pursuant to section one hundred eleven-k of the social services law or section four thousand one hundred thirty-five-b of the public health law shall establish the [~~paternity~~] **parentage** of and liability for the support of a child pursuant to this act. Such acknowledgment must be reduced to writing and filed pursuant to section four thousand one

hundred thirty-five-b of the public health law with the registrar of the district in which the birth occurred and in which the birth certificate has been filed. No further judicial or administrative proceedings are required to ratify an unchallenged acknowledgment of [~~**paternity**~~] **parentage**.

(b) (i) Where a signatory to an acknowledgment of [~~**paternity**~~] **parentage** executed pursuant to section one hundred eleven-k of the social services law or section four thousand one hundred thirty-five-b of the public health law had attained the age of eighteen at the time of execution of the acknowledgment, the signatory may seek to rescind the acknowledgment by filing a petition with the court to vacate the acknowledgment within the earlier of sixty days of the date of signing the acknowledgment or the date of an administrative or a judicial proceeding (including, but not limited to, a proceeding to establish a support order) relating to the child in which the signatory is a party. For purposes of this section, the "date of an administrative or a judicial proceeding" shall be the date by which the respondent is required to answer the petition.

(ii) Where a signatory to an acknowledgment of [~~**paternity**~~] **parentage** executed pursuant to section one hundred eleven-k of the social services law or section four thousand one hundred thirty-five-b of the public health law had not attained the age of eighteen at the time of execution of the acknowledgment, the signatory may seek to rescind the acknowledgment by filing a petition with the court to vacate the acknowledgment anytime up to sixty days after the signatory's attaining the age of eighteen years or sixty days after the date on which the respondent is required to answer a petition (including, but not limited to, a petition to establish a support order) relating to the child in which the signatory is a party, whichever is earlier; provided, however, that the signatory must have been advised at such proceeding of his or her right to file a petition to vacate the acknowledgment within sixty days of the date of such proceeding.

(iii) Where a petition to vacate an acknowledgment of [~~**paternity**~~] **parentage** has been filed in accordance with paragraph (i) or (ii) of this subdivision, the court shall order genetic marker tests or DNA tests for the determination of the child's [~~**paternity**~~] **parentage**. No such test shall be ordered, however, **where the acknowledgment was signed by the intended parent of a child born through assisted reproduction pursuant to subparagraph (ii) of paragraph (b) of subdivision one of section four thousand one hundred thirty-five-b of the public health law, or** upon a written finding by the court that it is not in the best interests of the child on the basis of res judicata, equitable estoppel, or the presumption of legitimacy of a child born to a married [~~**woman**~~] **person**. If the court determines, following the test, that the person who signed the acknowledgment is the [~~**father**~~] **parent** of the child, the court shall make a finding of [~~**paternity**~~] **parentage** and enter an order of [~~**filiation**~~] **parentage**. If the court determines that the person who signed the acknowledgment is not the [~~**father**~~] **parent** of the child, the acknowledgment shall be vacated.

(iv) After the expiration of the time limits set forth in paragraphs (i) and (ii) of this subdivision, any of the signatories to an acknowledgment of [~~**paternity**~~] **parentage** may challenge the acknowledgment in court by alleging and proving fraud, duress, or material mistake of fact. If the petitioner proves to the court that the acknowledgment of [~~**paternity**~~] **parentage** was signed under fraud, duress, or due to a material mistake of fact, the court shall then order genetic marker tests or DNA tests for the determination of the child's

[~~paternity~~] parentage. No such test shall be ordered, however, where the acknowledgment was signed by the intended parent of a child born through assisted reproduction pursuant to subparagraph (ii) of paragraph (b) of subdivision one of section four thousand one hundred thirty-five-b of the public health law, or upon a written finding by the court that it is not in the best interests of the child on the basis of res judicata, equitable estoppel, or the presumption of legitimacy of a child born to a married [~~woman~~] person. If the court determines, following the test, that the person who signed the acknowledgment is the [~~father~~] parent of the child, the court shall make a finding of [~~paternity~~] parentage and enter an order of [~~filiation~~] parentage. If the court determines that the person who signed the acknowledgment is not the [~~father~~] parent of the child, the acknowledgment shall be vacated.

(v) If, at any time before or after a signatory has filed a petition to vacate an acknowledgment of [~~paternity~~] parentage pursuant to this subdivision, the signatory dies or becomes mentally ill or cannot be found within the state, neither the proceeding nor the right to commence the proceeding shall abate but may be commenced or continued by any of the persons authorized by this article to commence a [~~paternity~~] parentage proceeding.

(c) An acknowledgment of parentage is void if, at the time of signing, any of the following are true:

(i) a person other than the signatories is a presumed parent of the child pursuant to section twenty-four of the domestic relations law;

(ii) a court has entered a judgment of parentage of the child;

(iii) another person has signed a valid acknowledgment of parentage with regard to the child;

(iv) the child has a parent pursuant to section 581-303 of the family court act other than the signatories;

(v) a signatory is a gamete donor under section 581-302 of the family court act; or

(vi) the acknowledgment is signed by a person who asserts that they are a parent under section 581-303 of the family court act of a child conceived through assisted reproduction, but the child was not conceived through assisted reproduction.

(d) Neither signatory's legal obligations, including the obligation for child support arising from the acknowledgment, may be suspended during the challenge to the acknowledgment except for good cause as the court may find. If the court vacates the acknowledgment of [~~paternity~~] parentage, the court shall immediately provide a copy of the order to the registrar of the district in which the child's birth certificate is filed and also to the putative father registry operated by the department of social services pursuant to section three hundred seventy-two-c of the social services law. In addition, if the [~~mother~~] parent of the child who is the subject of the acknowledgment is in receipt of child support services pursuant to title six-A of article three of the social services law, the court shall immediately provide a copy of the order to the child

support enforcement unit of the social services district that provides the [~~**mother**~~] **parent** with such services.

[~~**(d)**~~] **(e)** A determination of [~~**paternity**~~] **parentage** made by any other state, whether established through an administrative or judicial process or through an acknowledgment of [~~**paternity**~~] **parentage** signed in accordance with that state's laws, must be accorded full faith and credit pursuant to section 466(a)(11) of title IV-D of the social security act (42 U.S.C. § 666(a)(11)).

(f) Any reference to an acknowledgment of paternity in any law of this state, or any similar instrument signed in another state consistent with the law of that state shall be interpreted to mean an acknowledgment of parentage executed pursuant to section one hundred eleven-k of the social services law, section four thousand one hundred thirty-five-b of the public health law, or signed in another state consistent with the law of that state.

§ 16. Paragraph (b) of subdivision 1 of section 1017 of the family court act, as added by chapter 567 of the laws of 2015, is amended to read as follows:

(b) The court shall also direct the local commissioner of social services to conduct an investigation to locate any person who is not recognized to be the child's legal parent and does not have the rights of a legal parent under the laws of the state of New York but who (i) has filed with a putative father registry an instrument acknowledging [~~**paternity**~~] **parentage** of the child, pursuant to section 4-1.2 of the estates, powers and trusts law, or (ii) has a pending [~~**paternity**~~] **parentage** petition, or (iii) has been identified as a parent of the child by the child's other parent in a written sworn statement. The local commissioner of social services shall report the results of such investigation to the court and parties, including the attorney for the child.

§ 17. Section 4-1.2 of the estates, powers and trusts law, as amended by chapter 67 of the laws of 1981, the section heading, the opening paragraph of subparagraph 1 of paragraph (a), the opening paragraph of subparagraph 2 of paragraph (a) and the opening paragraph of subparagraph 3 of paragraph (a) as amended by chapter 595 of the laws of 1992, subparagraph 2 of paragraph (a) as amended by chapter 434 of the laws of 1987, clause (A) of subparagraph 2 of paragraph (a) as amended by chapter 170 of the laws of 1994, and clause (C) of subparagraph 2 of paragraph (a) and paragraph (b) as amended by chapter 64 of the laws of 2010, is amended to read as follows: § 4-1.2 Inheritance by non-marital children

(a) For the purposes of this article:

(1) A non-marital child is the legitimate child of his mother so that he and his issue inherit from his mother and from his maternal kindred.

(2) A non-marital child is the legitimate child of his father **or non-gestating intended parent** so that he and his issue inherit from [~~**his father and his paternal**~~] **such parent and such parent's** kindred if:

(A) a court of competent jurisdiction has, during the lifetime of the father, made an order of filiation **or parentage** declaring [~~**paternity**~~] **parentage** or the [~~**mother and father**~~] **parentage** of the child [~~**have executed**~~] **has been established through the execution of** an acknowledgment of [~~**paternity**~~] **parentage** pursuant to section four thousand one hundred thirty-five-b of the public health law, which has been filed with the registrar of the district in which the birth certificate has been filed or;

(B) the father of the child has signed an instrument acknowledging [~~**paternity**~~] **parentage**, provided that

(i) such instrument is acknowledged or executed or proved in the form required to entitle a deed to be recorded in the presence of one or more witnesses and acknowledged by such witness or witnesses, in either case, before a notary public or other officer authorized to take proof of deeds and

(ii) such instrument is filed within sixty days from the making thereof with the putative father registry established by the state department of social services pursuant to section three hundred seventy-two-c of the social services law, as added by chapter six hundred sixty-five of the laws of nineteen hundred seventy-six and

(iii) the department of social services shall, within seven days of the filing of the instrument, send written notice by registered mail to the mother and other legal guardian of such child, notifying them that an acknowledgment of [~~**paternity**~~] **parentage** instrument acknowledged or executed by such [~~**father**~~] **parent** has been duly filed or;

(C) [~~**paternity**~~] **parentage** has been established by clear and convincing evidence, which may include, but is not limited to: (i) evidence derived from a genetic marker test, or (ii) evidence that the [~~**father**~~] **parent** openly and notoriously acknowledged the child as his **or her** own, however nothing in this section regarding genetic marker tests shall be construed to expand or limit the current application of subdivision four of section forty-two hundred ten of the public health law.

(3) The existence of an agreement obligating the father to support the non-marital child does not qualify such child or his issue to inherit from the father in the absence of an order of filiation made or acknowledgement of [~~**paternity**~~] **parentage** as prescribed by subparagraph (2).

(4) A motion for relief from an order of filiation may be made only by the father and a motion for relief from an acknowledgement of [~~**paternity**~~] **parentage** may be made by [~~**the father, mother**~~] **a parent** or other legal guardian of such child, or the child, provided however, such motion must be made within one year from the entry of such order or from the date of written notice as provided for in subparagraph (2).

(b) If a non-marital child dies, his or her surviving spouse, issue, mother, maternal kindred, father and paternal kindred inherit and are entitled to letters of administration as if the decedent was a marital child, provided that the father and paternal kindred may inherit or obtain such letters only if the [~~**paternity**~~] **parentage** of the non-marital child has been established pursuant to any of the provisions of subparagraph (2) of paragraph (a).

§ 18. Subdivision 1, paragraph g of subdivision 2, subdivision 3, and subdivision 4 of section 111-c of the social services law, subdivision 1 as added by chapter 685 of the laws of 1975, paragraph g of subdivision 2 as added by chapter 809 of the laws of 1985, subdivision 3 as amended by chapter 398 of the laws of 1997, and subdivision 4 as added by chapter 343 of the laws of 2009, are amended to read as follows:

1. Each social services district shall establish a single organizational unit which shall be responsible for such district's activities in assisting the state in the location of absent parents, establishment of [~~paternity~~] **parentage** and enforcement and collection of support in accordance with the regulations of the department.

g. obtain from respondent, when appropriate and in accordance with the procedures established by section one hundred eleven-k of this chapter, an acknowledgement of [~~paternity~~] **parentage** or an agreement to make support payments, or both;

3. Notwithstanding the foregoing, the social services official shall not be required to establish the [~~paternity~~] **parentage** of any child born out-of-wedlock, or to secure support for any child, with respect to whom such official has determined that such actions would be detrimental to the best interests of the child, in accordance with procedures and criteria established by regulations of the department consistent with federal law.

4. a. A social services district represents the interests of the district in performing its functions and duties as provided in this title and not the interests of any party. The interests of a district shall include, but are not limited to, establishing [~~paternity~~] **parentage**, and establishing, modifying and enforcing child support orders.

b. Notwithstanding any other provision of law, the provision of child support services pursuant to this title does not constitute nor create an attorney-client relationship between the individual receiving services and any attorney representing or appearing for the district. A social services district shall provide notice to any individual requesting or receiving services that the attorney representing or appearing for the district does not represent the individual and that the individual has a right to retain his or her own legal counsel.

c. A social services district may appear in any action to establish [~~paternity~~] **parentage**, or to establish, modify, or enforce an order of support when an individual is receiving services under this title.

§ 19. Section 111-k of the social services law, as amended by chapter 398 of the laws of 1997, paragraphs (a) and (b) of subdivision 1 as amended by chapter 214 of the laws of 1998, is amended to read as follows:

§ 111-k. Procedures relating to acknowledgments of [~~paternity~~] **parentage**, agreements to support, and genetic tests. 1. A social services official or his or her designated representative who confers with a potential respondent or respondent, hereinafter referred to in this section as the "respondent", the mother of a child born out of wedlock and any other interested persons, pursuant to section one hundred eleven-c of this title, may obtain:

(a) an acknowledgment of [~~paternity~~] **parentage** of a child, as provided for in article five-B or section five hundred sixteen-a of the family court act, by a written statement, witnessed by two people not related to the signator or as provided for in section four thousand one hundred thirty-five-b of the public health law. Prior to the execution of such acknowledgment by the child's mother and the respondent, they shall be advised, orally, which may be through the use of audio or video equipment, and in writing, of the consequences of making such an acknowledgment. Upon the signing of an acknowledgment of [~~paternity~~] **parentage** pursuant to this section, the social services official or his or her representative shall file the original acknowledgment with the registrar.

(b) an agreement to make support payments as provided in section four hundred twenty-five of the family court act. Prior to the execution of such agreement, the respondent shall be advised, orally, which may be through the use of audio or video equipment, and in writing, of the consequences of such agreement, that the respondent can be held liable for support only if the family court, after a hearing, makes an order of support; that respondent has a right to consult with an attorney and that the agreement will be submitted to the family court for approval pursuant to section four hundred twenty-five of the family court act; and that by executing the agreement, the respondent waives any right to a hearing regarding any matter contained in such agreement.

2. (a) When the paternity of a child is contested, a social services official or designated representative may order the mother, the child, and the alleged father to submit to one or more genetic marker or DNA tests of a type generally acknowledged as reliable by an accreditation body designated by the secretary of the federal department of health and human services and performed by a laboratory approved by such an accreditation body and by the commissioner of health or by a duly qualified physician to aid in the determination of whether or not the alleged father is the father of the child. The order may be issued prior or subsequent to the filing of a petition with the court to establish paternity, shall be served on the parties by certified mail, and shall include a sworn statement which either (i) alleges [~~paternity~~] **parentage** and sets forth facts establishing a reasonable possibility of the requisite sexual contact between the parties, or (ii) denies [~~paternity~~] **parentage** and sets forth facts establishing a reasonable possibility that the party is not the father. The parties shall not be required to submit to the administration and analysis of such tests if they sign a voluntary acknowledgment of [~~paternity~~] **parentage** in accordance with paragraph (a) of subdivision one of this section, or if there has been a written finding by the court that it is not in the best interests of the child on the basis of res judicata, equitable estoppel**, the child was conceived through assisted reproduction** or the presumption of legitimacy of a child born to a married [~~woman~~] **person**.

(b) The record or report of the results of any such genetic marker or DNA test may be submitted to the family court as evidence pursuant to subdivision (e) of rule forty-five hundred eighteen of the civil practice law and rules where no timely objection in writing has been made thereto.

(c) The cost of any test ordered pursuant to this section shall be paid by the social services district provided however, that the alleged father shall reimburse the district for the cost of such test at such time as the alleged father's [~~paternity~~] **parentage** is established by a voluntary

acknowledgment of [~~paternity~~] **parentage** or an order of filiation. If either party contests the results of genetic marker or DNA tests, an additional test may be ordered upon written request to the social services district and advance payment by the requesting party.

(d) The parties shall be required to submit to such tests and appear at any conference scheduled by the social services official or designee to discuss the notice of the allegation of paternity or to discuss the results of such tests. If the alleged [~~father~~] **genetic parent** fails to appear at any such conference or fails to submit to such genetic marker or DNA tests, the social services official or designee shall petition the court to establish [~~paternity~~] **parentage**, provide the court with a copy of the records or reports of such tests if any, and request the court to issue an order for temporary support pursuant to section five hundred forty-two of the family court act.

3. Any reference to an acknowledgment of paternity in any law of this state or any similar instrument signed in another state consistent with the law of that state shall be interpreted to mean an acknowledgment of parentage executed pursuant to this section, section four thousand one hundred thirty-five-b of the public health law or signed in another state consistent with the law of that state.

§ 20. Subdivisions 1 and 2 of section 372-c of the social services law, as amended by chapter 139 of the laws of 1979, are amended to read as follows:

1. The department shall establish a putative father registry which shall record the names and addresses of: (a) any person adjudicated by a court of this state to be the [~~father~~] **parent** of a child born [~~out-of-wedlock~~] **out of wedlock**; (b) any person who has filed with the registry before or after the birth of a child [~~out-of-wedlock~~] **out of wedlock**, a notice of intent to claim [~~paternity~~] **parentage** of the child; (c) any person adjudicated by a court of another state or territory of the United States to be the father of an [~~out-of-wedlock~~] **out of wedlock** child, where a certified copy of the court order has been filed with the registry by such person or any other person; (d) any person who has filed with the registry an instrument acknowledging paternity pursuant to section 4-1.2 of the estates, powers and trusts law.

2. A person filing a notice of intent to claim [~~paternity~~] **parentage** of a child or an acknowledgement of paternity shall include therein his current address and shall notify the registry of any change of address pursuant to procedures prescribed by regulations of the department.

§ 21. Subdivision (a) of section 439 of the family court act, as amended by section 1 of chapter 468 of the laws of 2012, is amended to read as follows:

(a) The chief administrator of the courts shall provide, in accordance with subdivision (f) of this section, for the appointment of a sufficient number of support magistrates to hear and determine support proceedings. Except as hereinafter provided, support magistrates shall be empowered to hear, determine and grant any relief within the powers of the court in any proceeding under this article, articles five, five-A, [~~and~~] five-B **and five-C** and sections two hundred thirty-four and two hundred thirty-five of this act, and objections raised pursuant to section five thousand two hundred forty-one of the civil practice law and rules. Support

magistrates shall not be empowered to hear, determine and grant any relief with respect to issues specified in section four hundred fifty-five of this article, issues of contested [~~paternity~~] **parentage** involving claims of equitable estoppel, custody, visitation including visitation as a defense, **determinations of parentage made pursuant to section 581-407 of this act,** and orders of protection or exclusive possession of the home, which shall be referred to a judge as provided in subdivision (b) or (c) of this section. Where an order of filiation is issued by a judge in a paternity proceeding and child support is in issue, the judge, or support magistrate upon referral from the judge, shall be authorized to immediately make a temporary or final order of support, as applicable. A support magistrate shall have the authority to hear and decide motions and issue summonses and subpoenas to produce persons pursuant to section one hundred fifty-three of this act, hear and decide proceedings and issue any order authorized by subdivision (g) of section five thousand two hundred forty-one of the civil practice law and rules, issue subpoenas to produce prisoners pursuant to section two thousand three hundred two of the civil practice law and rules and make a determination that any person before the support magistrate is in violation of an order of the court as authorized by section one hundred fifty-six of this act subject to confirmation by a judge of the court who shall impose any punishment for such violation as provided by law. A determination by a support magistrate that a person is in willful violation of an order under subdivision three of section four hundred fifty-four of this article and that recommends commitment shall be transmitted to the parties, accompanied by findings of fact, but the determination shall have no force and effect until confirmed by a judge of the court.

§ 22. Subparagraph (D) of paragraph 17 of subsection (a) of section 1113 of the insurance law, as amended by chapter 551 of the laws of 1997, is amended to read as follows:

(D) **(i)(I)** Indemnifying an adoptive parent for verifiable expenses not prohibited under the law paid to or on behalf of the birth mother when either one or both of the birth parents of the child withdraw or withhold their consent to adoption. Such expenses may include maternity-connected medical or hospital expenses of the birth mother, necessary living expenses of the birth mother preceding and during confinement, travel expenses of the birth mother to arrange for the adoption of the child, legal fees of the birth mother, and any other expenses [~~which~~] **that** an adoptive parent may lawfully pay to or on behalf of the birth mother[~~.~~]**; or (II) Indemnifying an intended parent for financial loss incurred as a result of the failure by the person acting as surrogate to perform under the surrogacy contract due to death, bodily injury, sickness, disappearance of the person acting as surrogate, late miscarriage, or stillbirth. Such financial loss shall include medical and hospital expenses, insurance co-payments, deductibles, and coinsurance, necessary living expenses of the person acting as surrogate during the term of the surrogacy contract, travel expenses to arrange for the surrogacy, legal fees of the person acting as surrogate, and any other expenses that an intended parent may lawfully pay to or on behalf of the person acting as surrogate; and (ii)** For the purposes of this [~~section~~] **subparagraph** "adoptive parent" means the parent or his or her spouse seeking to adopt a child, "birth mother" means the biological mother of the child, "birth parent" means the biological mother or biological father of the child**, and the terms "donor", "intended parent", person acting as surrogate", and "surrogacy agreement" shall have the meaning set forth in section 581-102 of the family court act**; or

§ 23. Paragraph 32 of subsection (a) of section 1113 of the insurance law, as renumbered by chapter 626 of the laws of 2006, is renumbered paragraph 33 and a new paragraph 32 is added to read as follows:

(32) "Donor medical expense insurance" means insurance indemnifying an intended parent for medical or hospital expenses that the intended parent is contractually obligated to pay under a donor agreement when the expenses result from medical complications that occur as a result of the donation of gametes. For the purpose of this paragraph, "donor", "gametes" and "intended parent" shall have the meaning set forth in section 581-102 of the family court act.

§ 24. Subsection (a) of section 2105 of the insurance law, as amended by section 9 of part I of chapter 61 of the laws of 2011, is amended to read as follows:

(a) The superintendent may issue an excess line broker's license to any person, firm, association or corporation who or which is licensed as an insurance broker under section two thousand one hundred four of this article, or who or which is licensed as an excess line broker in the licensee's home state, provided, however, that the applicant's home state grants non-resident licenses to residents of this state on the same basis, except that reciprocity is not required in regard to the placement of liability insurance on behalf of a purchasing group or any of its members; authorizing such person, firm, association or corporation to procure, subject to the restrictions herein provided, policies of insurance from insurers which are not authorized to transact business in this state of the kind or kinds of insurance specified in paragraphs four through fourteen, sixteen, seventeen, nineteen, twenty, twenty-two, twenty-seven, twenty-eight [~~and~~], thirty-one, and thirty-two of subsection (a) of section one thousand one hundred thirteen of this chapter and in subsection (h) of this section, provided, however, that the provisions of this section and section two thousand one hundred eighteen of this article shall not apply to ocean marine insurance and other contracts of insurance enumerated in subsections (b) and (c) of section two thousand one hundred seventeen of this article. Such license may be suspended or revoked by the superintendent whenever in his or her judgment such suspension or revocation will best promote the interests of the people of this state.

§ 25. Subsection (b) of section 4101 of the insurance law, as amended by chapter 626 of the laws of 2006, is amended to read as follows:

(b) "Non-basic kinds of insurance" means the kinds of insurance described in the following paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter numbered therein as set forth in parentheses below:

accident and health (item (i) of (3));

non-cancellable disability (item (ii) of (3));

miscellaneous property (5);

water damage (6);

collision (12);

property damage liability (14) - non-basic as to mutual companies only;

motor vehicle and aircraft physical damage (19);

inland marine as specified in marine and inland marine (20);

marine protection and indemnity (21) - non-basic as to stock companies only;

residual value (22);

credit unemployment (24);

gap (26);

prize indemnification (27);

service contract reimbursement (28);

legal services insurance (29);

involuntary unemployment insurance (30);

salary protection insurance (31)**;**

donor medical expense insurance (32).

§ 26. Group A of table one as contained in paragraph 1 of subsection (a) of section 4103 of the insurance law, as amended by chapter 626 of the laws of 2006, is amended to read as follows: Group A:

7 $300,000 $150,000 8, 9, 10, 11, or 14 - for each such kind $100,000 $ 50,000 13 or 15 - for each such kind $500,000 $250,000 16 $900,000 $450,000 17 $400,000 $200,000 Basic additional amount required for any one or more of the above kinds of insurance $100,000 $ 50,000 3(i), 3(ii), 6{1} or 12{2} - for each such kind $100,000 $ 50,000 22 $2,000,000 $1,000,000 24 $400,000 $200,000 26(B) $200,000 $100,000 26(A), 26(C) or 26(D) - for each such kind $600,000 $300,000 27 $300,000 $150,000 28 $2,000,000 $1,000,000 30 $400,000 $200,000 31 $100,000 $ 50,000 **32 $100,000 $ 50,000**

§ 27. Group C of table three as contained in subsection (b) of section 4107 of the insurance law, as amended by chapter 626 of the laws of 2006, is amended to read as follows:

Group C: 3(i) or 3(ii) - for each such kind $ 100,000 $ 100,000 22 $3,000,000 $2,000,000 24 $ 300,000 $ 300,000 26 (B) $ 300,000 $ 200,000 26(A), 26(C) or 26(D) - for each such kind $ 900,000 $ 600,000 28 $3,000,000 $2,000,000 6{5}, 12{6} or 14{2} - for each such kind $

50,000 $ 50,000 27 $ 300,000 $ 150,000 30 $ 300,000 $ 300,000 31 $ 100,000 $ 100,000 **32 $ 100,000 $ 100,000**

§ 28. Section 4-1.3 of the estates, powers and trust law, as added by chapter 439 of the laws of 2014, is amended to read as follows: § 4-1.3 Inheritance by children conceived after the death of [**a genetic**]

an intended parent

(a) When used in this article, unless the context or subject matter manifestly requires a different interpretation:

(1) [**"Genetic parent" shall mean a man who provides sperm or a woman who provides ova used to conceive a child after the death of the man or woman.**

(2)] "Genetic material" shall mean sperm or ova provided by a genetic parent.

[**(3) "Genetic child" shall mean a child of the sperm or ova provided by a genetic parent, but only if and when such child is born.**]

(2) "Child" shall mean a child conceived through assisted reproduction.

(3) "Intended parent" shall have the same meaning as defined in section 581-102 of the family court act.

(b) For purposes of this article, a genetic child is the child of his or her [**genetic**] **intended** parent or parents and, notwithstanding paragraph (c) of section 4-1.1 of this part, is a distributee of his or her [**genetic**] **intended** parent or parents and, notwithstanding subparagraph (2) of paragraph (a) of section 2-1.3 of this chapter, is included in any disposition of property to persons described in any instrument of which [**a genetic**] **an intended** parent of the genetic child was the creator as the issue, children, descendants, heirs, heirs at law, next of kin, distributees (or by any term of like import) of the creator if it is established that:

(1) the [**genetic**] **intended** parent in a written instrument executed pursuant to the provisions of this section not more than seven years before the death of the [**genetic**] **intended** parent[**:**

(A)] expressly consented [**to the use of his or her genetic material to posthumously conceive his or her genetic child, and**

(B)] **that if assisted reproduction were to occur after the death of the intended parent, the deceased individual would be a parent of the child; and**

(2) the child was in utero no later than twenty-four months after the intended parent's death or born no later than thirty-three months after the intended parent's death.

(c) If the child was conceived using the genetic material of the intended parent, it must further be established that:

(1) the intended parent in a written instrument executed pursuant to the provisions of this section not more than seven years before the death of the intended parent authorized a person to make decisions about the use of the [~~genetic~~] **intended** parent's genetic material after the death of the [~~genetic~~] **intended** parent;

(2) the person authorized in the written instrument to make decisions about the use of the [~~genetic~~] **intended** parent's genetic material gave written notice, by certified mail, return receipt requested, or by personal delivery, that the [~~genetic~~] **intended** parent's genetic material was available for the purpose of conceiving a [~~genetic~~] child of the [~~genetic~~] **intended** parent, and such written notice was given;

(A) within seven months from the date of the issuance of letters testamentary or of administration on the estate of the [~~genetic~~] **intended** parent, as the case may be, to the person to whom such letters have issued, or, if no letters have been issued within four months of the death of the [~~genetic~~] **intended** parent, and

(B) within seven months of the death of the [~~genetic~~] **intended** parent to a distributee of the [~~genetic~~] **intended** parent; **and**

(3) the person authorized in the written instrument to make decisions about the use of the [~~genetic~~] **intended** parent's genetic material recorded the written instrument within seven months of the [~~genetic~~] **intended** parent's death in the office of the surrogate granting letters on the [~~genetic~~] **intended** parent's estate, or, if no such letters have been granted, in the office of the surrogate having jurisdiction to grant them[~~; and~~

~~(4) the genetic child was in utero no later than twenty-four months after the genetic parent's death or born no later than thirty-three months after the genetic parent's death~~].

[~~(c)~~] **(d)** The written instrument referred to in subparagraph (1) of paragraph (b) of this section **and subparagraph (1) of paragraph (c) of this section**:

(1) must be signed by the [~~genetic~~] **intended** parent in the presence of two witnesses who also sign the instrument **referred to in subparagraph (1) of paragraph (c) of this section**, both of whom are at least eighteen years of age and neither of whom is a person authorized under the instrument to make decisions about the use of the [~~genetic~~] **intended** parent's genetic material;

(2) may be revoked only by a written instrument signed by the [~~genetic~~] **intended** parent and executed in the same manner as the instrument it revokes;

(3) may not be altered or revoked by a provision in the will of the [~~genetic~~] **intended** parent;

(4) **an instrument referred to in subparagraph (1) of paragraph (c) of this section** may authorize an alternate to make decisions about the use of the [~~genetic~~] **intended** parent's genetic

material if the first person so designated dies before the [~~genetic~~] **intended** parent or is unable to exercise the authority granted; [~~and~~]

(5) **an instrument referred to in subparagraph (1) of paragraph (b) of this section may be substantially in the following form and must be signed and dated by the intended parent and properly witnessed:**

I, _____, (Your name and address)

consent to the use of assisted reproduction to conceive a child or children of mine after my death. I understand that, unless I revoke this consent and authorization in a written document signed by me in the presence of two witnesses who also sign the document, this consent and authorization will remain in effect for seven years from this day and that I cannot revoke or modify this consent and designation by any provision in my will. Signed this day of ,

_____ (Your signature)

Statement of witnesses: I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He or she signed this document in my presence. I am not the person authorized in this document to control the use of the genetic material of the person who signed this document.

Witness: Address: Date: Witness: Address: Date:

(6) may be substantially in the following form and must be signed and dated by the [~~genetic~~] **intended** parent and properly witnessed: I,

_____,

(Your name and address) consent to the use of my (sperm or ova) (referred to below as my "genetic material") to conceive a child or children of mine after my death, and I authorize

_____

(Name and address of person) to decide whether and how my genetic material is to be used to conceive a child or children of mine after my death. In the event that the person authorized above dies before me or is unable to exercise the authority granted I designate

_____

(Name and address of person) to decide whether and how my genetic material is to be used to conceive a child or children of mine after my death. I understand that, unless I revoke this consent and authorization in a written document signed by me in the presence of two witnesses who also sign the document, this consent and authorization will remain in effect for seven years

from this day and that I cannot revoke or modify this consent and designation by any provision in my will.

Signed this day of ,

_____ (Your signature) Statement of witnesses: I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He or she signed this document in my presence. I am not the person authorized in this document to control the use of the genetic material of the person who signed this document. Witness: Address: Date: Witness: Address: Date:

[~~(d)~~] **(e)** Any authority granted in a written instrument authorized by this section to a person who is the spouse of the [~~genetic~~] **intended** parent at the time of execution of the written instrument is revoked by a final decree or judgment of divorce or annulment, or a final decree, judgment or order declaring the nullity of the marriage between the [~~genetic~~] **intended** parent and the spouse or dissolving such marriage on the ground of absence, recognized as valid under the law of this state, or a final decree or judgment of separation, recognized as valid under the law of this state, which was rendered against the spouse.

[~~(e)~~] **(f)** Process shall not issue to a [~~genetic~~] child who is a distributee of [~~a genetic~~] **an intended** parent under sections one thousand three and one thousand four hundred three of the surrogate's court procedure act unless the child is in being at the time process issues.

[~~(f)~~] **(g)** Except as provided in paragraph (b) of this section with regard to any disposition of property in any instrument of which the [~~genetic~~] **intended** parent of a [~~genetic~~] child is the creator, for purposes of section 2-1.3 of this chapter a [~~genetic~~] child who is entitled to inherit from [~~a genetic~~] **an intended** parent under this section is a child of the [~~genetic~~] **intended** parent for purposes of a disposition of property to persons described in any instrument as the issue, children, descendants, heirs, heirs at law, next of kin, distributees (or by any term of like import) of the creator or of another. This paragraph shall apply to the wills of persons dying on or after September first, two thousand fourteen, to lifetime instruments theretofore executed which on said date are subject to the grantor's power to revoke or amend, and to all lifetime instruments executed on or after such date.

[~~(g)~~] **(h)** For purposes of section 3-3.3 of this chapter the terms "issue", "surviving issue" and "issue surviving" include a [~~genetic~~] child if he or she is entitled to inherit from his or her [~~genetic~~] **intended** parent under this section.

[~~(h)~~] **(i)** Where the validity of a disposition under the rule against perpetuities depends on the ability of a person to have a child at some future time, the possibility that such person may have a [~~genetic~~] child **conceived using assisted reproduction** shall be disregarded. This provision shall not apply for any purpose other than that of determining the validity of a disposition under the rule against perpetuities where such validity depends on the ability of a person to have a child at some future time. A determination of validity or invalidity of a disposition under the rule

against perpetuities by the application of this provision shall not be affected by the later birth of a [~~genetic~~] child **conceived using assisted reproduction** disregarded under this provision.

[~~(i)~~] **(j)** The use of a genetic material after the death of the person providing such material is subject exclusively to the provisions of this section and to any valid and binding contractual agreement between such person and the facility providing storage of the genetic material and may not be the subject of a disposition in an instrument created by the person providing such material or by any other person.

§ 29. This act shall take effect February 15, 2021, provided, however, that the amendments to subdivision (a) of section 439 of the family court act made by section twenty-one of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

A06832 Summary:

BILL NO A06832

SAME AS SAME AS

SPONSOR Paulin

COSPNSR

MLTSPNSR

Amd Fam Ct Act, generally; amd §123, Dom Rel L; amd §§1400, 1401, 1403 & 1404, Gen Bus L; amd §2599-cc, Pub Health L

Relates to the requirements of surrogacy programs and criteria for surrogacy arrangements.

A06832 Actions:

BILL NO A06832

04/12/2021 referred to judiciary

A06832 Committee Votes:

A06832 Floor Votes:

There are no votes for this bill in this legislative session.

A06832 Memo:

NEW YORK STATE ASSEMBLY
MEMORANDUM IN SUPPORT OF LEGISLATION
submitted in accordance with Assembly Rule III, Sec 1(f)

BILL NUMBER: A6832

SPONSOR: Paulin

TITLE OF BILL:

An act to amend the family court act, the general business law, the public health law and the domestic relations law, in relation to surrogacy programs and arrangements

PURPOSE:

To make necessary technical corrections to Part L of chapter 56 of the laws of 2020.

SUMMARY OF PROVISIONS:

Sections 1 through 20 make technical corrections to Article 5-C of the Family Court Act.

Section 21 makes a technical correction to section 123(2)(a) of the domestic relations law.

Sections 22 through 25 make technical corrections to Article 44 of the General Business Law.

Section 26 makes a technical correction to section 2599-cc of the public health law.

Section 27 provides the effective date.

JUSTIFICATION:

To make necessary technical corrections to provisions of the Family Court Act, the General Business Law, and the Public Health Law as added by Part L of chapter 56 of the laws of 2020.

LEGISLATIVE HISTORY:

New Bill

FISCAL IMPLICATIONS:

None

EFFECTIVE DATE:
This shall take effect immediately.

A06832 Text:

STATE OF NEW YORK

6832

2021-2022 Regular Sessions

IN ASSEMBLY

April 12, 2021

Introduced by M. of A. PAULIN -- read once and referred to the Committee on Judiciary

AN ACT to amend the family court act, the general business law, the public health law and the domestic relations law, in relation to surrogacy programs and arrangements

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 581-102 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-102. Definitions. (a) "Assisted reproduction" means a method of causing pregnancy other than sexual intercourse and includes but is not limited to:

1. intrauterine or vaginal insemination;
2. donation of gametes;
3. donation of embryos;
4. in vitro fertilization and transfer of embryos; and
5. intracytoplasmic sperm injection.

(b) "Child" means a born individual of any age whose parentage may be determined under this act or other law.

(c) "Compensation" means payment of any valuable consideration in excess of reasonable medical and ancillary costs.

(d) "Donor" means an individual who does not intend to be a parent who produces gametes and provides them to another person, other than the individual's spouse, for use in assisted reproduction. The term does not include a person who is a parent under part three of this article. Donor also includes an individual who had dispositional control of an embryo or gametes who then transfers dispositional control and releases all present and future parental and inheritance rights and obligations to a resulting child.

EXPLANATION--Matter in ***italics*** (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD10517-02-1

(e) "Embryo" means a cell or group of cells containing a diploid complement of chromosomes or group of such cells, not a gamete or gametes, that has the potential to develop into a live born human being if transferred into the body of a person under conditions in which gestation may be reasonably expected to occur.

(f) "Embryo transfer" means all medical and laboratory procedures that are necessary to effectuate the transfer of an embryo into the uterine cavity.

(g) "Gamete" means a cell containing a haploid complement of DNA that has the potential to form an embryo when combined with another gamete. Sperm and eggs shall be considered gametes. A human gamete used or intended for reproduction may not contain nuclear DNA that has been deliberately altered, or nuclear DNA from one human combined with the cytoplasm or cytoplasmic DNA of another human being.

(h) **"Health care practitioner" means an individual licensed or certified under title eight of the education law, or a similar law of another state or country, acting within his or her scope of practice.**

(i) "Independent escrow agent" means someone other than the parties to a surrogacy agreement and their attorneys. An independent escrow agent can, but need not, be a surrogacy program, provided such surrogacy program is owned [~~or managed~~] by an attorney licensed to practice law in the state of New York. If such independent escrow agent is not attorney owned, it shall be licensed, bonded and insured.

[~~(i) "Surrogacy agreement" is an agreement between at least one intended parent and a person acting as surrogate intended to result in a live birth where the child will be the legal child of the intended parents.~~]

(j) **"In vitro fertilization" means the formation of a human embryo outside the human body.**

(k) "Intended parent" is an individual who manifests the intent to be legally bound as the parent of a child resulting from assisted reproduction or a surrogacy agreement, provided he or she meets the requirements of this article.

(l) "Parent" as used in this article means an individual with a parent-child relationship created or recognized under this act or other law.

(m) "Participant" is an individual who either provides a gamete that is used in assisted reproduction, is an intended parent, is a person acting as surrogate, or is the spouse of an intended parent or person acting as surrogate.

(n) "Person acting as surrogate" means an adult person, not an intended parent, who enters into a surrogacy agreement to bear a child who will be the legal child of the intended parent or parents so long as the person acting as surrogate has not provided the egg used to conceive the resulting child.

[~~(k) "Health care practitioner" means an individual licensed or certified under title eight of the education law, or a similar law of another state or country, acting within his or her scope of practice.~~

~~(l) "Intended parent" is an individual who manifests the intent to be legally bound as the parent of a child resulting from assisted reproduction or a surrogacy agreement provided he or she meets the requirements of this article.~~

~~(m) "In vitro fertilization" means the formation of a human embryo outside the human body.~~

~~(n) "Parent" as used in this article means an individual with a parent-child relationship created or recognized under this act or other law.~~

~~(o) "Participant" is an individual who either: provides a gamete that is used in assisted reproduction, is an intended parent, is a person acting as surrogate, or is the spouse of an intended parent or person acting as surrogate.~~

~~(p)~~] **(o)** "Record" means information inscribed in a tangible medium or stored in an electronic or other medium that is retrievable in perceivable form.

[~~(q)~~] **(p)** "Retrieval" means the procurement of eggs or sperm from a gamete provider.

[~~(r)~~] **(q)** "Spouse" means an individual married to another, or who has a legal relationship entered into under the laws of the United States or of any state, local or foreign jurisdiction, which is substantially equivalent to a marriage, including a civil union or domestic partnership.

[~~(s)~~] **(r)** "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(s) "Surrogacy agreement" means an agreement between at least one intended parent and a person acting as surrogate intended to result in a live birth where the child will be the legal child of the intended parents.

(t) "Transfer" means the placement of an embryo or gametes into the body of a person with the intent to achieve pregnancy and live birth.

§ 2. Section 581-202 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-202. Proceeding for judgment of parentage of a child conceived through assisted reproduction. (a) A proceeding for a judgment of parentage with respect to a child conceived through assisted reproduction may be commenced:

(1) if [~~the~~] **an** intended parent or child resides in New York state, in the county where the intended parent resides any time after pregnancy is achieved or in the county where the child was born or resides **or in the county where the birth is scheduled to occur**; or

(2) if [~~the~~] **an** intended parent [~~and~~] **or** child do not reside in New York state**, in the county where the birth is scheduled to occur**, up to ninety days after the birth of the child in the county where the child was born.

(b) The petition for a judgment of parentage must be verified.

(c) Where a **verified** petition includes the following truthful statements, the court shall adjudicate the intended parent to be the parent of the child **without requiring a hearing unless the court, in its discretion, determines a hearing to be necessary to address the truthfulness of the statements**:

(1) a statement that an intended parent **or child** has been a resident of the state for at least six months**,** or if an intended parent **or child** is not a New York state resident, that the child [~~will be or was~~] **is scheduled to be** born in [~~the~~] **New York** state **or that the child was born in the state** within ninety days of filing; and

(2) a statement from the gestating intended parent that the gestating intended parent became pregnant as a result of assisted reproduction; and

(3) in cases where there is a non-gestating intended parent, a statement from the gestating intended parent and non-gestating intended parent that the non-gestating intended parent consented to assisted reproduction pursuant to section 581-304 of this article; and

(4) proof of any donor's donative intent.

(d) The following shall be deemed sufficient proof of a donor's donative intent for purposes of this section:

(1) [~~in the case of an anonymous donor or~~] where gametes or embryos have [~~previously~~] been [~~released~~] **relinquished** to a gamete or embryo storage facility or **were donated** in the presence of a health care practitioner, either:

(i) a statement or documentation from the gamete or embryo storage facility or health care practitioner stating or demonstrating that **the donor or donors of** such gametes or embryos [~~were anonymously donated or had previously been released~~] **relinquished all parental or proprietary interest to them**; [~~or~~]

(ii) **a record from the gamete or embryo donor or donors evidencing intent to relinquish all parental or proprietary interest in the gametes or embryos; or**

(iii) clear and convincing evidence that the gamete or embryo donor intended to donate gametes or embryos anonymously or intended to release such gametes or embryos to a gamete or embryo storage facility or health care practitioner; [~~or~~]

(2) [~~in the case of a donation from a known donor, either: a.~~] **Subparagraph one of this paragraph shall not apply where the person providing the gametes or embryos is the spouse of the intended parent;**

(3) where the gametes or embryos were not relinquished to a gamete or embryo storage facility or donated in the presence of a health care practitioner, a record from the gamete or embryo donor acknowledging the donation and confirming that the donor [~~has~~] **or donors have** no parental or proprietary interest in the gametes or embryos. The record shall be signed by the [~~gestating~~] intended parent **or parents** and the gamete or embryo donor **or donors**. The record may be, but is not required to be, signed:

(i) before a notary public, or

(ii) before two witnesses who are not the intended parents, or

(iii) before a health care practitioner; or

[~~b.~~] **(4)** clear and convincing evidence that the gamete or embryo donor agreed, prior to conception, with the [~~gestating~~] **intended** parent **or parents** that the donor [~~has~~] **or donors would have** no parental or proprietary interest in the gametes or embryos.

(e)[~~(1)~~] In the absence of evidence pursuant to [~~paragraph two of this~~] subdivision **(d) of this section**, notice shall be given to the donor at least twenty days prior to the date set for the proceeding to determine the existence of donative intent by delivery of a copy of the petition and notice pursuant to section three hundred eight of the civil practice law and rules. **Such notice shall also be given to the gestating intended parent, if any, and the gestating intended parent's spouse, if any, each of whom shall be a necessary party.** Upon a showing to the court, by affidavit or otherwise, on or before the date of the proceeding or within such further time as the court may allow, that personal service cannot be effected at the [~~donor's~~] last known address **or addresses of the donor or donors, gestating intended parent, if any, and/or the gestating intended parent's spouse, if any,** with reasonable effort, notice may be given, without prior court order therefore, at least twenty days prior to the proceeding by registered or certified

mail directed to the [~~donor's~~] last known address. Notice by publication shall not be required to be given to a donor entitled to notice pursuant to the provisions of this section.

[~~(2) Notwithstanding the above, where sperm is provided under the supervision of a health care practitioner to someone other than the sperm provider's intimate partner or spouse without a record of the sperm provider's intent to parent notice is not required.~~]

(f) In cases not covered by subdivision (c) of this section, the court shall adjudicate the parentage of the child consistent with part three of this article.

(g) Where the requirements of subdivision (c) of this section are met or where the court finds the intended parent **or parents** to be a parent under subdivision [~~(c)~~] **(f)** of this section, the court shall issue a judgment of parentage:

(1) declaring[~~, that~~] **the intended parent or parents to be the legal parent or parents of the child immediately** upon the birth of the child[~~, the intended parent or parents is or are the legal parent or parents of the child~~]; and

(2) ordering the intended parent or parents to assume responsibility for the maintenance and support of the child immediately upon the birth of the child; and

(3) if there is a donor **or donors**, ordering that [~~the~~] **any** donor is not a parent of the child; and

(4) ordering that:

(i) Pursuant to section two hundred fifty-four of the judiciary law, the clerk of the court shall transmit to the state commissioner of health, or for a person born in New York city, to the commissioner of health of the city of New York, on a form prescribed by the commissioner, a written notification of such entry together with such other facts as may assist in identifying the birth record of the person whose parentage was in issue and, if such person whose parentage has been determined is under eighteen years of age, the clerk shall also transmit forthwith to the registry operated by the department of social services pursuant to section three hundred seventy-two-c of the social services law a notification of such determination; and

(ii) Pursuant to section forty-one hundred thirty-eight of the public health law and NYC Public Health Code section 207.05 that upon receipt of a judgment of parentage the local registrar where a child is born will report the parentage of the child to the appropriate department of health in conformity with the court order. If an original birth certificate has already been issued, the appropriate department of health will amend the birth certificate in an expedited manner and seal the previously issued birth certificate except that it may be rendered accessible to the child at eighteen years of age or the legal parent or parents.

§ 3. Section 581-203 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-203. Proceeding for judgment of parentage of a child conceived pursuant to a surrogacy agreement. (a) The proceeding may be commenced (1) in any county where an intended parent resided any time after the surrogacy agreement was executed; (2) in the county where the child was born or resides **or in the county where the birth is scheduled to occur**; or (3) in the county where the surrogate resided any time after the surrogacy agreement was executed.

(b) The proceeding may be commenced at any time after [~~the surrogacy agreement has been executed~~] **pregnancy is achieved** and the person acting as surrogate**, the spouse of the person acting as surrogate, if any,**

donors for whom there is not proof of donative intent as set forth in subdivision (d) of section 581-202 of this part, and all intended parents are necessary parties. **The service provisions of subdivision (e) of section 581-202 of this title shall be applicable to donors entitled to notice pursuant to this provision.**

(c) The petition for a judgment of parentage must be verified and include the following:

(1) a statement that the person acting as surrogate or at least one [~~of the~~] intended [~~parents~~] **parent** has been a resident of the state for at least six months at the time the surrogacy agreement was executed; and

(2) a certification from the attorney representing the intended parent or parents **and the spouse of the person acting as a surrogate, if applicable,** and the attorney representing the person acting as surrogate that the requirements of part four of this article have been met; and

(3) a statement from all parties to the surrogacy agreement that they knowingly and voluntarily entered into the surrogacy agreement and that the parties are jointly requesting the judgment of parentage.

(d) Where the court finds the statements required by subdivision (c) of this section to be true, the court shall issue a judgment of parentage, without additional proceedings or documentation:

(1) declaring, that upon the birth of the child born during the term of the surrogacy agreement, the intended parent or parents are the only legal parent or parents of the child;

(2) declaring, that upon the birth of the child born during the term of the surrogacy agreement, the person acting as surrogate, and the spouse of the person acting as surrogate, if [~~any~~] **applicable**, is not the legal parent of the child;

(3) declaring that upon the birth of the child born during the term of the surrogacy agreement, [~~the~~] **any** donors, if [~~any~~] **applicable**, [~~are~~] not [~~the parents~~] **a parent** of the child;

(4) ordering the person acting as surrogate and the spouse of the person acting as surrogate, if any, to transfer the child to the intended parent or parents if this has not already occurred;

(5) ordering the intended parent or parents to assume responsibility for the maintenance and support of the child immediately upon the birth of the child; and

(6) ordering that:

(i) Pursuant to section two hundred fifty-four of the judiciary law, the clerk of the court shall transmit to the state commissioner of health, or for a person born in New York city, to the commissioner of health of the city of New York, on a form prescribed by the commissioner, a written notification of such entry together with such other facts as may assist in identifying the birth record of the person whose parentage was in issue and, if the person whose parentage has been determined is under eighteen years of age, the clerk shall also transmit to the registry operated by the department of social services pursuant to section three hundred seventy-two-c of the social services law a notification of the determination; and

(ii) Pursuant to section forty-one hundred thirty-eight of the public health law and NYC Public Health Code section 207.05 that upon receipt of a judgement of parentage the local registrar where a child is born will report the parentage of the child to the appropriate department of health in conformity with the court order. If an original birth certificate has already been issued, the appropriate department of health will amend the birth certificate in an expedited manner and seal the previ-

ously issued birth certificate except that it may be rendered accessible to the child at eighteen years of age or the legal parent or parents.

(e) In the event the certification required by paragraph two of subdivision (c) of this section cannot be made because of a technical or non-material deviation from the requirements of this article; the court may nevertheless enforce the agreement and issue a judgment of parentage if the court determines the agreement is in substantial compliance with the requirements of this article. In the event that any other requirements of subdivision (c) of this section are not met, the court shall determine parentage according to part four of this article.

§ 4. Section 581-205 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-205. Inspection of records. Court records relating to proceedings under this article shall be sealed, provided, however, that the office of temporary and disability assistance, a child support unit of a social services district or a child support agency of another state providing child support services pursuant to title IV-d of the federal social security act, when a party to a related support proceeding and to the extent necessary to provide child support services or for the administration of the program pursuant to title IV-d of the federal social security act, may obtain a copy of a judgment of parentage. The parties to the proceeding and the child shall have the right to inspect and make copies of the entire court record, including, but not limited to, the name of the person acting as surrogate and any known [~~**donors**~~] **donor**.

§ 5. Subdivision (a) of section 581-206 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

(a) Proceedings pursuant to this article may be instituted in [~~**the**~~] **New York state** supreme [~~**or**~~] **court,** family court or surrogates court.

§ 6. Subdivision (b) of section 581-303 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

(b) The court shall issue a judgment of parentage pursuant to this article upon application by any [~~**participant**~~] **person authorized to file a petition pursuant to subdivision (c) of section 581-201 of this article**.

§ 7. Subdivision (d) of section 581-306 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

(d) An embryo disposition agreement or advance directive that is not in compliance with subdivision (a) of this section may still be found to be enforceable by the court after balancing the respective interests of the parties except that the intended parent who divested him or herself of legal rights and dispositional control may not be declared to be a parent for any purpose without his or her consent. The **intended** parent awarded legal rights and dispositional control of the embryos shall, in this instance, be declared to be the only parent of the child.

§ 8. Section 581-402 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-402. Eligibility to enter surrogacy agreement. (a) A person acting as surrogate shall be eligible to enter into an enforceable surrogacy agreement under this article if the person acting as surrogate has met the following requirements at the time the surrogacy agreement is executed:

(1) the person acting as surrogate is at least twenty-one years of age;

(2) the person acting as surrogate**: (i)** is a United States citizen or a lawful permanent resident**,** and[**~~, where at least one intended parent is not~~**] **(ii) has been** a resident of New York state for six months[**~~, was~~**] **if neither intended parent has been** a resident of New York state for at least six months;

(3) the person acting as surrogate has not provided the egg used to conceive the resulting child;

(4) the person acting as surrogate has completed a medical evaluation with a health care practitioner relating to the anticipated pregnancy. Such medical evaluation shall include a screening of the medical history of the potential surrogate including known health conditions that may pose risks to the potential surrogate or embryo during pregnancy;

(5) the person acting as surrogate has given informed consent for the surrogacy **arrangement** after the licensed health care practitioner inform them of the medical risks of surrogacy including the possibility of multiple births, risk of medications taken for the surrogacy, risk of pregnancy complications, psychological and psychosocial risks, and impacts on their personal lives;

(6) the person acting as surrogate, and the spouse of the person acting as surrogate, if applicable, have been represented throughout the contractual process and **shall be represented throughout** the duration of the [**~~contract and its execution~~**] **surrogacy arrangement** by independent legal counsel of their own choosing who is licensed to practice law in the state of New York which shall be paid for by the intended parent or parents**,** except that a person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents pay the fee for such legal counsel. Where the [**~~intended parent or parents are paying for the~~**] independent legal counsel of the person acting as surrogate, and the spouse of the person acting as surrogate, if applicable, **is paid by the intended parent or parents,** a separate retainer agreement shall be prepared clearly stating that such legal counsel will only represent the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, in all matters pertaining to the surrogacy [**~~agreement~~**] **arrangement**, that such legal counsel will not offer legal advice to any other parties to the surrogacy agreement, and that the attorney-client relationship lies with the person acting as surrogate and the spouse of the person acting as surrogate, if applicable**. The intended parent or parents shall not be required to pay the legal fees for the person acting as surrogate, and the spouse of the person acting as surrogate, if applicable, in connection with a litigated dispute between the parties unless otherwise ordered by an arbiter or court of competent jurisdiction**;

(7) the person acting as surrogate has or the surrogacy agreement stipulates that the person acting as surrogate will obtain [**~~a comprehensive~~**] health insurance [**~~policy~~**] **coverage** that takes effect prior to taking any medication or commencing treatment to further embryo transfer that covers [**~~preconception care, prenatal care, major medical treatments, hospitalization, and behavioral health care, and the comprehensive policy has a term that extends throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy; the policy shall be paid for, whether directly or through reimbursement or other means, by the intended parent or parents on behalf of the person acting as surrogate pursuant to the surrogacy agreement, except that a person acting as surrogate who is receiving no compensation may waive the right to have the intended~~**

~~parent or parents pay for the health insurance policy. The intended parent or parents shall also pay for or reimburse the person acting as surrogate for all co-payments, deductibles and any other out-of-pocket medical costs associated with preconception, pregnancy, childbirth, or postnatal care, that accrue through twelve months after the birth of the child, a stillbirth, a miscarriage, or termination of the pregnancy. A person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents make such payments or reimbursements~~];

(i) preconception medical expenses. The surrogacy agreement shall state that the intended parent or parents will be responsible for all medical costs of the person acting as surrogate associated with their pre-conception care including but not limited to medical and psychological screenings, medications, embryo transfer procedure, monitoring subsequent to the embryo transfer procedure and any complications associated with the foregoing. The intended parent or parents shall be responsible for the costs of any such complications either through insurance or by placing and maintaining sufficient funds in escrow to cover such expenses. If the surrogacy agreement is terminated before a pregnancy is achieved, such funds shall remain in escrow for a minimum period of six months from the date the surrogacy agreement is terminated;

(ii) medical expenses associated with pregnancy. The person acting as surrogate has, or the surrogacy agreement shall stipulate that the person acting as surrogate will obtain, comprehensive health insurance coverage, via one or more insurance policies, prior to or immediately upon confirmation of pregnancy that covers prenatal care, childbirth and postnatal care, and that such comprehensive coverage must be in place throughout the duration of the pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of the pregnancy, or termination of the pregnancy. The policy shall be paid for, whether directly or through reimbursement or other means, by the intended parent or parents on behalf of the person acting as surrogate to the extent that there is an additional cost to the person acting as surrogate for such health insurance coverage. The intended parent or parent shall also pay for or reimburse the person acting as surrogate for all co-payments, deductibles and any other out-of-pocket medical costs associated with pregnancy, childbirth, or postnatal care, that accrue through twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of the pregnancy, or termination of the pregnancy; and

(iii) uncompensated surrogacy arrangements. A person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents make the payments set forth in this section;

(8) the surrogacy agreement must provide that the intended parent or parents shall [~~procure and~~] pay for a life insurance, contractual liability or accidental death insurance policy for the person acting as surrogate that takes effect prior to taking any medication or the commencement of medical procedures to further embryo transfer, provides a minimum benefit of seven hundred fifty thousand dollars or the maximum amount the person acting as surrogate qualifies for if less than seven hundred fifty thousand dollars, and [~~has a term that extends~~] such coverage shall extend throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy, with a beneficiary or beneficiaries of [~~their~~] the person

acting as surrogate's choosing. The policy shall be paid for, whether directly or through reimbursement or other means, by the intended parent or parents on behalf of the person acting as surrogate pursuant to the surrogacy agreement, except that a person acting as surrogate who is receiving no compensation may waive the right to have the intended parent or parents pay for the life insurance**, contractual liability or accidental death insurance** policy; and

(9) the person acting as surrogate meets all other requirements deemed appropriate by the commissioner of health regarding the health of the prospective surrogate.

(b) The intended parent or parents shall be eligible to enter into an enforceable surrogacy agreement under this article if he, she or they have met the following requirements at the time the surrogacy agreement was executed:

(1) at least one intended parent is**:**

(i) a United States citizen or a lawful permanent resident**;** and

[~~was~~] **(ii) has been** a resident of New York state for at least six months **if the person acting as surroagte has not been a resident of the state of New York for at least six months**;

(2) [~~the intended parent or parents has~~] **they have** been represented throughout the contractual process and **shall be represented throughout** the duration of the [~~contract and its execution~~] **surrogacy arrangement** by independent legal counsel of his, her or their own choosing who is licensed to practice law in the state of New York; and

(3) [~~he or she is~~] **they are** an adult person who is not in a spousal relationship, or [~~adult~~] **any two adults who are** spouses together, or any two adults who are intimate partners together, except an adult in a spousal relationship is eligible to enter into an enforceable surrogacy agreement without [~~his or her~~] **their** spouse if:

(i) they are living separate and apart pursuant to a decree or judgment of separation or pursuant to a written agreement of separation subscribed by the parties thereto and acknowledged or proved in the form required to entitle a deed to be recorded; or

(ii) they have been living separate and apart for at least three years prior to execution of the surrogacy agreement.

(c) where the spouse of an intended parent is not a required party to the agreement, the spouse is not an intended parent and shall not have rights or obligations to the child.

§ 9. Section 581-403 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-403. Requirements of surrogacy agreement. A surrogacy agreement shall be deemed to have satisfied the requirements of this article and be enforceable if it meets the following requirements:

(a) it shall be in a [~~signed~~] record [~~verified or executed before~~] **with each signature either notarized or witnessed by** two [~~non-party witnesses~~] **non-parties and signed** by:

(1) each intended parent, and

(2) the person acting as surrogate, and the spouse of the person acting as surrogate, if [~~any~~] **applicable**, unless:

(i) [~~the person acting as surrogate and the spouse of the person acting as surrogate~~] **they** are living separate and apart pursuant to a decree or judgment of separation or pursuant to a written agreement of separation subscribed by the parties thereto and acknowledged or proved in the form required to entitle a deed to be recorded; or

(ii) **they** have been living separate and apart for at least three years prior to execution of the surrogacy agreement;

(b) it shall be executed prior to the person acting as surrogate taking any medication or the commencement of medical procedures in the furtherance of embryo transfer, provided the person acting as surrogate shall have provided informed consent to undergo such medical treatment or medical procedures prior to executing the agreement;

(c) it shall be executed by a person acting as surrogate meeting the eligibility requirements of subdivision (a) of section 581-402 of this part and by the spouse of the person acting as surrogate**, if applicable**, unless the signature of the spouse of the person acting as surrogate is not required as set forth in this section;

(d) it shall be executed by intended parent or parents who met the eligibility requirements of subdivision (b) of section 581-402 of this part;

(e) the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, and the intended parent or parents shall have been represented throughout the contractual process and the **surrogacy agreement states that they shall be represented throughout the** duration of the [~~**contract and its execution**~~] **surrogacy arrangement** by separate, independent legal counsel of their own choosing;

(f) if the surrogacy agreement provides for the payment of compensation to the person acting as surrogate, the funds for base compensation and reasonable anticipated additional expenses shall have been placed in escrow with an independent escrow agent, who consents to the jurisdiction of New York courts for all proceedings related to the enforcement of the escrow agreement, prior to the person acting as surrogate commencing [~~**with**~~] any medical procedure other than medical evaluations necessary to determine the person acting as surrogate's eligibility;

(g) the surrogacy agreement must include information disclosing how the intended parent or parents will cover the medical expenses of the person acting as surrogate and the child. **The surrogacy agreement shall specify the amount that the intended parent or parents shall place in escrow to cover such reasonable anticipated costs including preconception medical care and extending throughout the duration of the expected pregnancy, and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in the termination of the pregnancy, or termination of the pregnancy or until the surrogacy agreement is terminated if pregnancy is not achieved.** If **it is anticipated that** comprehensive health care coverage [~~**is**~~] **will be** used to cover the medical expenses **for the person acting as surrogate**, the [~~**disclosure shall include a review and summary of the**~~] health care policy provisions related to coverage and exclusions for the person acting as [~~**surrogate's**~~] **surrogate shall be reviewed and summarized in relation to the anticipated** pregnancy **prior to such policy being used to cover any of the person acting as surrogate's medical expenses incurred pursuant to the surrogacy arrangement**; and

(h) [~~**it**~~] **the surrogacy arrangement** shall include the following information:

(1) the date, city and state where the surrogacy agreement was executed;

(2) the first and last names of and contact information for the intended parent or parents and of the person acting as surrogate;

(3) the first and last names of and contact information for the persons from which the gametes originated, if known. The agreement shall specify whether the gametes provided were eggs, sperm, or embryos;

(4) the name of and contact information for the licensed and registered surrogacy program handling the surrogacy agreement**, if any**; and

(5) the name of and contact information for the attorney representing the person acting as surrogate, and the spouse of the person acting as surrogate, if applicable, and the attorney representing the intended parent or parents; and

(i) the surrogacy agreement must comply with all of the following terms:

(1) As to the person acting as surrogate and the spouse of the person acting as surrogate, if applicable:

(i) the person acting as surrogate agrees to undergo embryo transfer and attempt to carry and give birth to the child;

(ii) the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, agree to surrender custody of all resulting children to the intended parent or parents immediately upon birth;

(iii) the surrogacy agreement shall include the name of the attorney representing the person acting as surrogate and, if applicable, the spouse of the person acting as surrogate;

(iv) the surrogacy agreement must include an acknowledgement by the person acting as surrogate and the spouse of the person acting as surrogate, if applicable, that they have received a copy of the Surrogate's Bill of Rights from their legal counsel;

(v) the surrogacy agreement must permit the person acting as surrogate to make all health and welfare decisions regarding themselves and their pregnancy including but not limited to, whether to consent to a cesarean section or multiple embryo transfer, and notwithstanding any other provisions in this chapter, provisions in the agreement to the contrary are void and unenforceable. This article does not diminish the right of the person acting as surrogate to terminate or continue a pregnancy;

(vi) the surrogacy agreement shall permit the person acting as a surrogate to utilize the services of a health care practitioner of the person's choosing;

(vii) the surrogacy agreement shall not limit the right of the person acting as surrogate to terminate or continue the pregnancy or reduce or retain the number of fetuses or embryos the person is carrying;

(viii) the surrogacy agreement shall provide for the right of the person acting as surrogate, upon request, to obtain counseling to address issues resulting from the person's participation in the surrogacy [~~**agreement**~~] **arrangement**, including, but not limited to, counseling following delivery. The cost of that counseling shall be paid by the intended parent or parents;

(ix) the surrogacy agreement must include a notice that any compensation received pursuant to the agreement may affect **the eligibility of** the person acting as [~~**surrogate's ability**~~] **surrogate and the person acting as surrogate's spouse, if applicable,** for public benefits or the amount of such benefits; and

(x) the surrogacy agreement shall provide that, upon the person acting as surrogate's request, the intended parent or parents [~~**have or will procure and**~~] **shall** pay for a disability insurance policy [~~**for**~~] **or other insurance policy to cover any lost wages incurred by** the person acting as surrogate **in connection with their participation in the surrogacy arrangement**; the person acting as surrogate may designate the beneficiary of the person's choosing. **In the event that such insurance coverage is not available, the intended parent or parents shall reimburse the**

person acting as surrogate for any lost wages they incur in connection with their participation in the surrogacy arrangement.

(2) As to the intended parent or parents:

(i) the intended parent or parents agree to accept custody of all resulting children immediately upon birth regardless of number, gender, or mental or physical condition and regardless of whether the intended **embryo or** embryos **was or** were transferred due to a laboratory error without diminishing the rights, if any, of anyone claiming to have a superior parental interest in the child; and

(ii) the intended parent or parents [~~**agree to**~~] **shall** assume responsibility for the support of all resulting children immediately upon birth; and

(iii) the surrogacy agreement shall include the name of the attorney representing the intended parent or parents; and

(iv) the surrogacy agreement shall provide that the rights and obligations of the intended parent or parents under the surrogacy agreement are not assignable; and

(v) the intended parent or parents [~~**agree to**~~] **shall** execute a will, prior to the embryo transfer, designating a guardian for all resulting children and authorizing their executor to perform the [~~**intended parent's or parents'**~~] obligations **of the intended parent or parents** pursuant to the surrogacy agreement.

§ 10. Subdivision (b) of section 581-404 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

(b) The subsequent separation or divorce of the intended parents does not affect the rights, duties and responsibilities of the intended parents as outlined in the surrogacy agreement. After the execution of a surrogacy agreement under this article, the subsequent spousal relationship of the intended parent does not affect the validity of a surrogacy agreement, and the consent of the spouse of [~~**the**~~] **an** intended parent to the agreement shall not be required.

§ 11. Section 581-405 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-405. Termination of surrogacy agreement. After the execution of a surrogacy agreement but before the person acting as surrogate becomes pregnant by means of assisted reproduction, the person acting as surrogate, the spouse of the person acting as surrogate, if applicable, or any intended parent may terminate the surrogacy agreement by giving notice of termination in a record to all other parties. Upon proper termination of the surrogacy agreement the parties are released from all obligations recited in the surrogacy agreement except that the intended parent or parents [~~**remains**~~] **shall remain** responsible for all [~~**expenses that are reimbursable**~~] **lost wages and other financial obligations which have accrued** under the agreement [~~**which have been incurred by the person acting as surrogate**~~] through the date of termination. If the intended parent or parents terminate the surrogacy agreement pursuant to this section after the person acting as surrogate has taken any medication or commenced treatment to further embryo transfer, such intended parent or parents shall be responsible for paying [~~**for or reimbursing the person acting as surrogate for all co-payments, deductibles,**~~] any other out-of-pocket medical costs[~~**, and any other economic losses**~~] incurred within twelve months of the termination of the agreement [~~**and**~~] **which, as documented by a health care practitioner, are** associated with taking such medication or undertaking such treatment. Unless the agreement provides

otherwise, the person acting as surrogate is entitled to keep all payments received and obtain all payments to which the person is entitled up until the date of termination of the agreement. Neither a person acting as surrogate nor the spouse of the person acting as surrogate, if [~~any~~] **applicable**, is liable to the intended parent or parents for terminating a surrogacy agreement as provided in this section.

§ 12. Section 581-406 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-406. Parentage under compliant surrogacy agreement. Upon the birth of a child conceived by assisted reproduction under a surrogacy agreement that complies with this part, each intended parent is, by operation of law, a parent of the child and neither the person acting as [~~a~~] surrogate nor the person's spouse, if [~~any~~] **applicable**, is a parent of the child.

§ 13. Section 581-409 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-409. Dispute as to surrogacy agreement. (a) Any dispute which is related to a surrogacy agreement other than disputes as to parentage**, which are not resolved through alternative dispute resolution methods** shall be resolved by the supreme court, which shall determine the respective rights and obligations of the parties[~~, in~~]**. In** any proceeding initiated pursuant to this section, the court may, at its discretion, authorize the use of conferencing or mediation at any point in the proceedings.

(b) Except as expressly provided in the surrogacy agreement[~~, the intended parent or parents and the person acting as surrogate shall be entitled to all remedies available at law or equity in any dispute related to the surrogacy agreement.~~

~~(c) There shall be no specific performance remedy available for a breach~~] **or subdivisions (c) or (d) of this section, if the agreement is breached by the person acting as surrogate or one or more intended parent, the non-breaching party shall be entitled to all remedies available at law or in equity in any dispute related to the surrogacy agreement.**

(c) Specific performance shall not be a remedy available for a breach by a person acting as surrogate of a provision in the surrogacy agreement that the person acting as surrogate be impregnated, agree to a multiple embryo transfer, terminate or not terminate a pregnancy, or submit to medical procedures including a cesarean section.

(d) If any intended parent is determined to be the parent of the child, specific performance is a remedy available for: (1) breach of the surrogacy agreement by a person acting as surrogate which prevents the intended parent or parents from exercising the full rights of parentage immediately upon the birth of the child; or (2) breach by the intended parent or parents which prevents their acceptance of the duties of parentage immediately upon the birth of the child.

(e) In any proceeding initiated pursuant to this section, where the supreme court determines that the dispute involves both contractual and parentage issues, the court may order that the portion of the proceedings raising parentage issues may be transferred to the family or surrogate's court.

§ 14. Section 581-502 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-502. Compensation. (a) Compensation may be paid to a donor or person acting as surrogate based on medical risks, physical discomfort, inconvenience and the responsibilities they are undertaking in connection with their participation in the assisted reproduction. Under no circumstances may compensation be paid to purchase gametes or embryos or for the release of a parental interest in a child.

(b) The compensation, if any, paid to a donor or person acting as surrogate must be reasonable and negotiated in good faith between the parties, and said payments to a person acting as surrogate shall not exceed the duration of the pregnancy and **a minimum** recuperative period of [~~up to~~] eight weeks after the birth of any resulting children.

(c) Compensation may not be conditioned upon the purported quality or genome-related traits of the gametes or embryos.

(d) Compensation may not be conditioned on actual genotypic or phenotypic characteristics of the donor **or donors** or of any resulting children.

(e) Compensation to [~~an~~] **any** embryo donor shall be limited to storage fees, transportation costs and attorneys' fees.

§ 15. Section 581-601 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-601. Applicability. The rights enumerated in this part shall apply to any person acting as surrogate [~~in~~] **under the laws of** this state, notwithstanding any surrogacy agreement, judgment of parentage, memorandum of understanding, verbal agreement or contract to the contrary. Except as otherwise provided by law, any written or verbal agreement purporting to waive or limit any of the rights in this part is void as against public policy. The rights enumerated in this part are not exclusive, and are in addition to any other rights provided by law, regulation, or a surrogacy agreement that meets the requirements of this article.

§ 16. Section 581-603 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-603. Independent legal counsel. A person acting as surrogate**,** **and the spouse of the person acting as surrogate, if applicable,** has the right to be represented throughout the contractual process and the duration of the surrogacy [~~**agreement and its execution**~~] **arrangement** by independent legal counsel of their own choosing who is licensed to practice law in the state of New York, to be paid for by the intended parent or parents. **The intended parent or parents shall not be required to pay the legal fees for the person acting as surrogate, and the spouse of the person acting as surrogate, if applicable, in connection with a litigated dispute between the parties unless otherwise ordered by an arbiter or court of competent jurisdiction.**

§ 17. Section 581-604 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-604. Health insurance and medical costs. A person acting as surrogate has the right to have a comprehensive health insurance policy that covers preconception [~~**care, prenatal care, major medical treatments, hospitalization and behavioral health care**~~] **medical expenses and medical expenses associated with the pregnancy** for a term that extends throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy, to be paid

for by the intended parent or parents. [~~The intended parent or parents shall also pay for or reimburse the person acting as surrogate for all co-payments, deductibles and any other out-of-pocket medical costs associated with pregnancy, childbirth, or postnatal care that accrue through~~] **In addition, a person acting as a surrogate shall have the right to have the intended parent or parents pay for all of their medical expenses incurred in connection with the surrogacy arrangement, continuing through the duration of the expected pregnancy and for** twelve months after the birth of the child, a stillbirth, a miscarriage **resulting in the termination of pregnancy**, or the termination of the pregnancy. A person acting as a surrogate who is receiving no compensation may waive the right to have the intended parent or parents make such payments or reimbursements.

§ 18. Section 581-605 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-605. Counseling. A person acting as surrogate has the right to [~~obtain a comprehensive health insurance policy that covers behavioral health care and will cover the cost of psychological~~] **mental health** counseling to address issues resulting from their participation in [~~a~~] **the** surrogacy [~~and such policy~~] **arrangement, which** shall be paid for by **an insurance policy or by** the intended parent or parents.

§ 19. Section 581-606 of the family court act, as added by section 1 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 581-606. Life insurance**, contractual liability, or accidental death insurance policy**. A person acting as surrogate has the right to be provided a life insurance**, contractual liability or accidental death insurance** policy that takes effect prior to taking any medication or commencement of treatment to further embryo transfer, provides a minimum benefit of seven hundred fifty thousand dollars, or the maximum amount the person acting as surrogate [~~qualifying~~] **qualifies** for [~~it~~] **if** less than seven hundred fifty thousand dollars, and [~~has a term that extends~~] **such coverage shall extend** throughout the duration of the expected pregnancy and for twelve months after the birth of the child, a stillbirth, a miscarriage resulting in termination of pregnancy, or termination of the pregnancy, with a beneficiary or beneficiaries of [~~their~~] **the person acting as surrogate's** choosing, to be paid for by the intended parent or parents.

§ 20. The family court act is amended by adding a new section 581-705 to read as follows:

§ 581-705. A court adjudicating the parentage of a child conceived through assisted reproduction or adjudicating the enforceability of an embryo disposition agreement may apply to section 581-202 and part three of this article retroactively. The participants in a surrogacy arrangement that involved the payment of compensation prior to February fifteenth, two thousand twenty-one shall not be eligible to receive a judgment of parentage pursuant to section 581-203 or section 581-406 of this article, but shall be entitled to seek a judgment of parentage pursuant to section 581-407 of this article.

§ 21. Paragraph (a) of subdivision 2 of section 123 of the domestic relations law, as amended by section 5 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

(a) Any party to a genetic surrogate parenting agreement or the spouse of any [~~part~~] **party** to a genetic surrogate parenting agreement who

violate this section shall be subject to a civil penalty not to exceed five hundred dollars.

§ 22. Subdivision (c) of section 1400 of the general business law, as added by section 11 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

(c) "Surrogacy program" does not include any party to a surrogacy agreement or any person licensed to practice law and representing a party to the surrogacy agreement, but does include and is not limited to any agency, agent, business, or individual engaged in, arranging, or facilitating transactions contemplated by a surrogacy agreement, regardless of whether such agreement ultimately comports with the requirements of article five-C of the family court act. **Any person licensed to practice law shall be deemed a surrogacy program only in those cases where such person is providing matching services to the intended parent or parents and the person acting as a surrogate.**

§ 23. Section 1401 of the general business law, as added by section 11 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

§ 1401. Surrogacy programs regulated under this article. The provisions of this article apply to surrogacy programs arranging or facilitating transactions contemplated by a surrogacy agreement**, regardless of whether such agreement ultimately comports with the requirements** under part four of article five-C of the family court act if:

(a) The surrogacy program does business in New York state; **or**

(b) A person acting as surrogate who is party to a surrogacy agreement resides in New York state [~~**during the term**~~] **at the time** of the surrogacy agreement[~~**; or**~~

~~**(c) Any medical procedures under the surrogacy agreement are performed in New York state**~~] **is executed**.

§ 24. Subdivisions (a) and (f) of section 1403 of the general business law, as added by section 11 of part L of chapter 56 of the laws of 2020, are amended to read as follows:

(a) Shall keep all funds paid by or on behalf of the intended parent or parents **other than funds paid to the surrogacy program for its fees,** in an escrow account separate from its operating accounts; and

(f) Shall be licensed to operate in New York state pursuant to regulations promulgated by the department of health in consultation with the department of financial services[~~**, once such regulations are promulgated and become effective**~~]; and

§ 25. Subdivision 1 of section 1404 of the general business law, as added by section 11 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

1. The department of health, in consultation with the department of financial services, shall promulgate rules and regulations to implement the requirements of this article regarding surrogacy programs and assisted reproduction service providers in a manner that ensures the safety and health of gamete providers and persons serving as surrogates. Such regulations shall:

(a) Require surrogacy programs to monitor compliance with [~~**surrogacy agreements**~~] eligibility [~~**and requirements in state law**~~] **criteria and for the intended parents and persons acting as surrogates under this article**; and

(b) Require the [~~**surrogacy programs and**~~] assisted reproduction service providers to administer informed consent procedures that comply with regulations promulgated by the department of health under section twenty-five hundred ninety-nine-cc of the public health law.

§ 26. The opening paragraph of paragraph (c) of subdivision 1 of section 2599-cc of the public health law, as added by section 12 of part L of chapter 56 of the laws of 2020, is amended to read as follows:

the establishment of a voluntary central tracking registry of persons acting as surrogates, as reported by [~~**surrogacy programs licensed by the department pursuant to article forty-four of the general business law**~~] **assisted reproduction service providers** upon the affirmative consent of a person acting as surrogate. Such registry shall provide a means for gathering and maintaining accurate information on the:

§ 27. This act shall take effect immediately.

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Gestational Surrogacy Fact Sheet

This fact sheet provides basic information about gestational surrogacy. Gestational surrogacy is a type of surrogacy where the surrogate does not provide the egg for fertilization.

There is another type of surrogacy called "genetic surrogacy." This fact sheet does not cover genetic surrogacy. Recent changes to laws in New York do not cover genetic surrogacy. For questions about genetic surrogacy, talk with your health care provider or infertility specialist.

If you are interested in learning more about gestational surrogacy, visit the resources at the end of this sheet, or talk with a health care professional or an attorney who specializes in surrogacy.

What is gestational surrogacy?

Gestational surrogacy is a process where one person, who did not provide the egg used in conception, carries a fetus through pregnancy and gives birth to a baby for another person or couple. The person who carries the fetus is called a "surrogate" or "gestational carrier." The person or couple who are seeking to parent the baby or babies are called the "intended parent(s)."

Who chooses surrogacy to become a parent?

Many people choose surrogacy as a way to start or add to their family. Most commonly, intended parents are:

- Not able to have children because of infertility;
- Not able to safely give birth to a child because of health conditions;
- Same-sex male couples;
- Transgender individuals or couples; or
- Prospective single males.

Who can be a surrogate?

Surrogates should have had healthy pregnancies in the past and a desire to help intended parents who are unable to have children. A surrogate may carry a fetus for someone they don't know, or for a friend or relative.

What does it take to be a surrogate or an intended parent?

Surrogates must be screened to make sure they are healthy enough to have a baby. Medical guidelines, including Department of Health surrogacy screening guidelines, recommend that surrogates be between 21 and 45 years of age, have had at least one healthy pregnancy and a full-term delivery without complications. Medical screening includes:

- blood tests and other lab work;
- a physical exam;
- a psychosocial exam; and
- consultation with the health care provider.

Other screenings may be ordered by health care providers who are experts in surrogacy and reproductive health. These screenings help to make sure that the surrogate is medically appropriate to serve as a surrogate and fully understands any potential risks.

Intended parents are screened to make sure they are ready to begin the surrogacy process. This includes being physically, mentally and legally capable of parenting and can afford potential costs associated with the surrogacy process.

If an intended parent is providing the egg or sperm, they may be screened for various health issues, as well as genetic conditions. Genetic screening is not done to reveal physical characteristics not harmful to a baby, like hair color, eye color or sex.

New York State law requires certain New York State residency requirements for the intended parent(s) and surrogate (*see*Family Court Act § 581-402[a],[b]).

Who else is involved in the gestational surrogacy process?

- **Attorneys:** The surrogate and the intended parent(s) must be represented by separate legal counsel who are licensed in New York State and have expertise in surrogacy matters. The attorneys draft and review legal documents to make sure their client(s)' (the surrogate or intended parent(s)) interests are protected. They also help their client(s) understand their rights and responsibilities included in the surrogacy agreement.
- **Surrogacy matching programs:** Some intended parents may go through a surrogacy matching program, also called a *surrogacy agency*. These programs:
    - coordinate the many services that are part of the surrogacy process;
    - work to make sure that everyone's interests are protected;
    - can refer the surrogate and intended parent(s) to attorneys who can help them with the legal aspects of surrogacy;
    - can refer the intended parents and surrogates to qualified health care providers.

In New York State, surrogacy programs must be licensed by the New York State Department of Health and follow the Department's guidelines.

- **Egg and sperm donors:**Some intended parents choose to use sperm or egg(s) from a sperm or egg bank. There are many reasons why they may choose to use donated sperm or eggs. In New York State, gestational surrogates cannot donate their own eggs as part of a surrogacy agreement.
- **Health care providers**: Some health care providers specialize in surrogacy arrangements. These providers include:
    - An *obstetrician* or *obstetrician/gynecologist* (an OB/GYN): a doctor with training in pregnancy and reproduction. They provide the primary medical care for the surrogate during the pregnancy. Other health care providers, including nurse midwives, nurses and doulas may also be involved in the surrogate's care.

  - A *reproductive endocrinologist*: an obstetrician who also has special training in diagnosing and treating infertility. They use medical procedures like in vitro fertilization, or IVF, to help surrogates become pregnant.
  - A *fertility clinic* or *IVF clinic*: A group of providers who provide medical screening and services required by those who need medical help to achieve a pregnancy.
- **Mental health professionals:** Mental health professionals meet with the surrogate and their partner (if any) to make sure that they are emotionally prepared for the surrogacy process. This includes assessing that they have thought through the potential emotional risks and the impact of the process on their families. Intended parents also meet with mental health professionals, to make sure that they understand the surrogacy process and are able to care for the child.

If I am using surrogacy, will others know about my health information?

Privacy and confidentiality are very important. All professionals that work with surrogates and intended parents must keep their client(s)' medical information private and confidential. They also cannot share information about the child being born through surrogacy.

A surrogate may be asked to share information about their medical history and the health of the pregnancy with the intended parent(s).

Surrogates and intended parents often meet in person before the pregnancy. They usually keep in contact during the pregnancy. The intended parent(s) are usually at the hospital during the child's birth.

How does surrogacy work?

The first step in surrogacy is for the intended parent(s) to select a surrogate. The surrogate and intended parent(s) are screened to make sure they are healthy (both physically and emotionally) and are able to participate in the surrogacy process. Once a surrogate is matched with the intended parent(s), the parties work with their separate attorneys to write, review, revise and sign the surrogacy agreement. This happens before the start of any medical procedures (other than screening tests.)

The surrogacy agreement describes the rights and responsibilities of the surrogate and the intended parent(s) and the promises (agreement) the parties are making to one another. New York State law is very specific about the requirements of the agreement (*see*Family Court Act § 581-403). Surrogacy matching programs and attorney for the surrogate and intended parent(s) must ensure that all requirements are met under New York State law to ensure the agreement is legally binding and enforceable, and to best protect the interests and rights of all parties to the agreement.

After the surrogacy agreement is signed, an embryo can be transferred into the surrogate through IVF. IVF is a medical procedure where an egg is fertilized with sperm in a laboratory. This creates an embryo that is transferred into the surrogate's uterus. The surrogate usually takes medication before the embryo is transferred. This makes the IVF procedure more likely to result in a pregnancy.

What is included in a surrogacy agreement and required under New

York law?

Surrogates have a right to the following, to be provided and paid for by the intended parent(s):

- the right to comprehensive health insurance coverage. This insurance must cover the surrogate through the entire surrogacy process, from the time the surrogate takes any medications before or after the embryo transfer, throughout the pregnancy, and for 12 months after the pregnancy ends (whether resulting in the child's birth, stillbirth, or termination of the pregnancy);
- a disability insurance policy;
- a life insurance policy;
- a comprehensive health insurance policy that covers mental health counseling; and
- compensation for legal fees.

Surrogates also have the following rights under New York law:

- the right to select a health care professional of their own choosing;
- the right to terminate or continue the pregnancy;
- the right to make health and welfare decisions about themselves and the pregnancy, including the right to reduce or retain the number of fetuses or embryos they are carrying;
- the right to receive compensation for the surrogacy, which must be held in escrow with an independent escrow agent; and
- the right to be provided with a copy of the Surrogate's Bill of Rights.

The surrogacy agreement is a long document, and includes additional information related to the surrogacy process.

Surrogacy matching programs and attorneys for the surrogate and intended parent(s) must refer to the full legal requirements set forth in New York law, including but not limited to the requirements for a surrogacy agreement, set forth in Family Court Act Article 5-C, Part 4, and the Surrogate's Bill of Rights, set forth in Family Court Act Article 5-C, Part 6. The above lists are not intended to be exhaustive or serve as legal guidance.

How much does surrogacy cost?

Surrogacy can be costly, and the price range varies. Costs can include legal fees, medical expenses, surrogacy agency fees, the surrogate's compensation, and other miscellaneous expenses. Many surrogacy arrangements cost between $60,000 and $150,000.

Are there risks with being a surrogate?

Yes, anyone considering surrogacy must be aware of the potential risks associated with being a surrogate. There are health risks to the surrogate as with any pregnancy. Most pregnant people have mild or moderate symptoms like nausea and vomiting, minor swelling, and fatigue. In rare cases, pregnant people experience more serious medical complications, including death, even if they were healthy before becoming pregnant. These risks will be discussed as part of the surrogacy process, and surrogates must be screened for possible

health risks.

Getting routine health care during and after a pregnancy is an important part of the surrogacy process. This may help identify any health problems before they become severe.

For more information on the health risks associated with pregnancy, talk with your health care provider or visit Pregnant or Just Had a Baby? Know When to Call for Help - Fast!.

Being a surrogate can be time-consuming and emotional. If the surrogate is married, that person generally must also be involved and willingly cooperate in the surrogacy arrangement. Although not genetically related, the surrogate may become attached to the baby they are carrying. While most surrogates experience joy and pride because of the vital role they play in assisting the intended parent(s) to have a child, some surrogates may find the process emotionally challenging.

Are there risks to Intended Parent(s) using a surrogate?

There may be emotional and financial risks for the intended parent(s). For example, the intended parent(s) can become emotionally attached to a surrogate but frustrated by their lack of control over the surrogate's lifestyle and pregnancy. Also, there is no guarantee that the surrogate will become pregnant after the embryo is transferred in their uterus, and each cycle of IVF can be costly. There may be complications during the pregnancy which may put the surrogate's health, or the health of the fetus, at risk. Finally, there is no guarantee that the pregnancy will go to term and or that the child will be born healthy.

Where can I find out more about infertility and surrogacy?

- American Society for Reproductive Medicine
- The National Infertility Association

Recommendations for practices utilizing gestational carriers: a committee opinion

Practice Committee of the American Society for Reproductive Medicine and Practice Committee of the Society for Assisted Reproductive Technology

American Society for Reproductive Medicine, Birmingham, Alabama

This document provides the latest recommendations for evaluation of gestational carriers and intended parents. It incorporates recent information from the US Centers for Disease Control and Prevention, the US Food and Drug Administration, and the American Association of Tissue Banks, with which all programs offering gestational carrier services must be thoroughly familiar. This document replaces the previous document of the same name, last published in 2015 (Fertil Steril® 2015; 103:e1–8). (Fertil Steril® 2017;107:e3–10. ©2016 by American Society for Reproductive Medicine.)

STATEMENT OF PURPOSE

The following recommendations are intended to provide guidance for when it is appropriate to consider using a gestational carrier, provide guidelines for screening and testing of genetic parents and gestational carriers to reduce the possibility of complications, and to address the complex medical and psychological issues that confront the gestational carrier and intended parents, as well as the children. A gestational carrier is defined as a woman who carries a pregnancy and is not sexually intimate with the genetic parents or gamete donors. These guidelines incorporate recent information about optimal screening and testing for sexually transmitted infections (STI) and psychological assessments.

The current document represents an effort to make the screening procedures for individuals involved in third-party reproduction using a gestational carrier more consistent and incorporates recent information from the US Centers for Disease Control and Prevention (CDC), US Food and Drug Administration (FDA), and American Association of Tissue Banks (AATB). These recommendations use terminology from the federal agencies in addition to the AATB. In that context, the term "screening" refers to specific historical factors that place an individual at a higher risk for a given disease, such as human immunodeficiency virus (HIV) and transmissible spongiform encephalopathy (TSE), or Creutzfeldt-Jakob disease (CJD). "Testing" refers to specific laboratory studies, such as serologic tests. The distinction between screening and testing is consistent within the document. The term "ineligible" does not mean excluded, but eligible with appropriate informed consent. These recommendations for the screening and testing of gestational carriers and the genetic parents apply to individuals in the United States. Because the prevalence of STIs and genetic diseases may vary in other geographic areas, these recommendations may not be appropriate for other countries or individuals who come to the United States from other countries. Whereas the FDA does not require screening or testing of the gestational carrier, the American Society for Reproductive Medicine (ASRM) recommends testing these individuals as described.

Other areas where the ASRM recommendations may be more stringent than the FDA minimum requirements are noted in the text. Additionally, state requirements may be more restrictive than the FDA, and clinics should be aware of minimum screening and testing requirements for their state.

1. Indications for the use of a gestational carrier
   a. Gestational carriers may be used when a true medical condition precludes the intended parent from carrying a pregnancy or would pose a significant risk of death or harm to the woman or the fetus. The indication must be clearly documented in the patient's medical record. Examples of such medical indications would include:

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i. Absence of uterus (congenital or acquired)
ii. Significant uterine anomaly (e.g., irreparable Asherman syndrome; unicornuate uterus associated with recurrent pregnancy loss)
iii. Absolute medical contraindication to pregnancy (e.g., pulmonary hypertension)
iv. Serious medical condition that could be exacerbated by pregnancy or cause significant risk to the fetus
v. Biologic inability to conceive or bear a child, such as single male or homosexual male couple

b. Gestational carriers may be considered when an unidentified endometrial factor exists, such as for patients with multiple unexplained previous in vitro fertilization (IVF) failures despite transfer of good-quality embryos.
c. No owner, operator, laboratory director, or employee of the practice may serve as a carrier or intended parent in that practice.

2. Intended parents
a. Psychosocial education

The decision to use a gestational carrier is complex, and patients and their partners (if applicable) may benefit from psychosocial education to aid in this decision. The physician should strongly recommend psychosocial education and counseling by a qualified mental health professional to all intended parents. The assessment should include a clinical interview and, where appropriate, psychological testing. Psychological test data should be handled in accordance with American Psychological Association ethical standards (1). The clinician should refer patients in whom factors appear to warrant further evaluation to a qualified mental health professional. The potential impact of the relationship between the intended parent and carrier should be explored, as should any plans that may exist relating to disclosure and future contact (see section titled "Psychosocial consultation for gestational carriers and intended parents," 4.a.).

b. Screening and testing of genetic parents.
i. Genetic parents should undergo appropriate genetic evaluation. Universal testing should be considered for diseases that are common in all genetic backgrounds (such as cystic fibrosis and spinal muscular atrophy). Targeted testing based on ethnicity should be considered for diseases that are common to certain ethnicities (such as sickle cell, TaySachs, etc.).
ii. The genetic parents should undergo a complete medical evaluation, including a thorough history and physical examination, to ensure that they are healthy enough to proceed with procedures involving assisted reproductive technology (ART).
iii. Genetic parents must be screened in the same manner as gamete donors (2–4). Prospective genetic parents with any identified risk factors based on screening questionnaires are considered ineligible according to guidelines issued by the FDA. According to current FDA guidelines, embryos created by such individuals can still be transferred into a gestational carrier provided that the tissue is labeled to indicate any associated increased risks and that physicians transferring the embryos are aware of the status of the results. Although the FDA does not require that the gestational carrier be informed of the results of the screening, ASRM recommends that embryos created using gametes from individuals considered ineligible should only be transferred to a gestational carrier who is adequately informed and counseled regarding the associated potential risks.
iv. Before acceptance, and within 6 months of creating the embryos to be transferred, the genetic parents must undergo a complete physical examination (Society for Assisted Reproductive Technology [SART] physical examination forms, www.sart.org). When any of the following is present, the genetic parents are considered ineligible (see above).
1. Physical evidence for risk of sexually transmitted disease, such as genital ulcerative lesions, herpes simplex, chancroid, and urethral discharge
2. Physical evidence of risk for syphilis or evidence of syphilis
3. Physical evidence of anal intercourse in the male partner, including perianal condylomata
4. Physical evidence of nonmedical percutaneous drug use, such as needle tracks; the examination should include examination of tattoos, which might obscure needle tracks
5. Physical evidence of recent tattooing, ear piercing, or body piercing (within the past 12 months) where sterile technique was not used
6. Disseminated lymphadenopathy
7. Unexplained oral thrush
8. Blue or purple spots consistent with Kaposi sarcoma
9. Unexplained jaundice, hepatomegaly, or icterus
10. Large scab consistent with recent history of smallpox immunization
11. Eczema vaccinatum, generalized vesicular rash, severely necrotic lesion (consistent with vaccinia necrosum), or corneal scarring (consistent with vaccinial keratitis)

v. Laboratory testing

There is no method that completely ensures that infectious agents will not be transmitted to the gestational carrier. However, the following guidelines, combined with an adequate medical history and

specific exclusion of individuals at high risk for HIV and other STIs should significantly reduce these risks. The FDA requires that the following tests be performed within 30 days of oocyte retrieval and within 7 days of sperm collection, using methods approved specifically for purposes of determining donor eligibility, and that negative results be documented before use of the genetic parent's gametes. Tests using nucleic acid testing (NAT) technology to target sequences located in specific genes adequately and appropriately reduce the risk of transmission of these relevant communicable agents. The list of test methods approved by the FDA for the purpose of donor screening is available at the following website, http://www.fda.gov/BiologicsBloodVaccines/BloodBloodProducts/ApprovedProducts/LicensedProductsBLAs/BloodDonorScreening/InfectiousDisease/UCM080466

1. Human immunodeficiency virus (HIV)-1 antibody and NAT
2. HIV-2 antibody
3. HIV group O antibody. Establishments that do not use an FDA-licensed test for HIV group O antibodies must evaluate the genetic parents for risk associated with HIV group O infection with additional screening questions (see "risk factor questionnaire for donors," available at www.sart.org).
4. Hepatitis C antibody and NAT
5. Hepatitis B surface antigen
6. Hepatitis B core antibody immunoglobulin G [IgG] and immunoglobulin M [IgM]
7. Serologic test for syphilis
8. Additional testing for the female genetic parent must include:
   a. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* NAT on urine or a swab obtained from the cervix, urethral meatus, or vagina. Because there are no tests licensed, approved, or cleared by the FDA for screening donors for *N. gonorrhea* and *C. trachomatis*, the laboratory must use an FDA-licensed, -approved, or -cleared test labeled for the detection of these organisms in an asymptomatic, low-prevalence population.
9. Additional testing for the male genetic parent must include:
   a. *N. gonorrhoeae* and *C. trachomatis* testing using a NAT on urine or a swab obtained from the urethral meatus using an FDA-licensed, -approved, or -cleared test labeled for the detection of these organisms in an asymptomatic, low-prevalence population.
   b. (Human T-lymphotropic virus HTLV)-1 and HTLV-2
   c. Cytomegalovirus (CMV) (IgG and IgM)
10. ASRM recommends testing the genetic parents' blood type and Rhesus (Rh) factor. If there is the potential for Rh incompatibility, couples should be informed about the obstetric significance of this condition.

vi. Managing laboratory results

1. A positive test should be confirmed before notifying the potential genetic parent. If a test is confirmed positive, the individual should be referred for appropriate counseling and management.
2. Individuals with false-positive test results for syphilis using non-treponemal assays that are confirmed to be negative using a treponemal-based assay are considered eligible.
3. Individuals with positive tests for syphilis, *N. gonorrhoeae*, or *C. trachomatis* should be treated, retested, and deferred from creating embryos for use in a gestational carrier for 12 months after documentation that treatment was successful before being reconsidered. If evidence is presented documenting successful treatment more than 12 months prior, no further deferral is needed as long as current testing does not indicate an active infection.
4. Men who test positive for active CMV infection (positive urine or throat culture or paired serum samples demonstrating a 4-fold rise in IgG antibody and IgM antibody at least 30% of the IgG level) should be excluded until signs of active infection are no longer present. There are many strains of CMV, and superinfection in the gestational carrier is possible even if she is CMV IgG positive. The risk of CMV transmission and newborn CMV infection from an embryo transfer is extremely low, and such infants appear to have no significant illness or other abnormality.
5. Individuals who initially test positive for HIV-1 antibody and NAT, HIV-2 antibody, HIV group O antibody, hepatitis C antibody and NAT, hepatitis B surface antigen, hepatitis B core antibody (IgG and IgM), and HTLV-1 and HTLV-2 are considered ineligible. According to current FDA guidelines, embryos created by such individuals can still be transferred into a gestational carrier provided that the tissue is labeled to indicate any associated increased risks and that physicians transferring the embryos are aware of the status of the results. Although the FDA does not require that recipients be informed of the test results, in the opinion of the ASRM, recipients must be informed and counseled appropriately before such embryos can be transferred into a gestational carrier.

vii. Quarantining of embryos

All potential gestational carriers should be offered the option of cryopreserving and

quarantining embryos derived from the genetic parents for 180 days, with release of embryos only after the genetic parents have been retested with confirmed negative results (see section on Laboratory Testing for intended parents, 2.v.1–10). However, couples also should be informed that historically embryo cryopreservation had lower implantation rates. The gestational carrier should be counseled appropriately in the event of seroconversion of a genetic parent after cryopreservation of the embryos.

viii. Record keeping

The FDA requires that records pertaining to each genetic parent (screening and test results) be maintained for at least 10 years. However, in the opinion of the ASRM, a permanent record of each intended parent's initial screening, testing, and subsequent follow-up evaluations should be maintained. To the extent possible, the clinical outcome for each cycle should be recorded. A mechanism must exist to maintain such records as a future medical resource for any offspring produced.

1. Protection of confidentiality: Individuals participating in gestational carrier programs should be assured that their confidentiality and medical information will be protected insofar as federal and local statutes permit. Medical records detailing the eligibility of the intended parents should be maintained as stipulated by federal and local requirements.

ix. Legal issues and informed consent

1. The genetic parents should be counseled regarding the risks and adverse effects of ovarian stimulation and retrieval, with such counseling documented in the patients' permanent medical records.
2. Intended parents must have ongoing legal counsel by an appropriately qualified legal practitioner who is experienced with third-party reproduction and licensed to practice in the relevant state or states, or in the event of an international arrangement, in addition to any relevant states, in the intended parent(s)' home country.

3. Gestational carriers

a. Selection and evaluation of gestational carriers

i. Psychosocial evaluation and counseling by a qualified mental health professional area strongly recommended for all potential gestational carriers and their partners. The assessment should include a clinical interview and, where appropriate, psychological testing. Psychological test data should be handled in accordance with American Psychological Association ethical standards (1). The clinician should refer patients in whom factors appear to warrant further evaluation to a qualified mental health professional. The potential impact of the relationship between the gestational carrier and intended parent should be explored, as well as any plans that may exist relating to disclosure and future contact (see section on Laboratory Testing, 4.a.).

1. The psychosocial evaluation and counseling should consider the impact of the pregnancy on family and community dynamics.
2. Carriers must be of legal age, and preferably between the ages of 21 and 45 years. Certain situations may dictate the use of a carrier older than 45 years of age, but all parties involved must be informed about the potential risks of pregnancy with advancing maternal age.
3. Ideally, the carrier should have had at least one, term, uncomplicated pregnancy before being considered as a gestational carrier for another couple.
4. Ideally, the carrier should not have had more than a total of five previous deliveries or three deliveries via cesarean section.
5. Ideally, the carrier should have a stable family environment with adequate support to help her cope with the added stress of pregnancy.

b. Screening and testing of a gestational carrier

i. A complete personal and sexual history should be obtained to identify individuals who might be at high risk for HIV, STIs, or other acquired infections that might be transmissible to the fetus. Although the FDA does not require screening or testing of gestational carriers for possible transmissible infectious diseases to the fetus, ASRM recommends testing of all gestational carriers and their partners within 30 days before embryo transfer to protect the health and interests of all parties involved (see www.sart.org for screening questionnaire).

ii. Before acceptance, the potential gestational carrier should undergo a complete medical evaluation by a qualified medical professional and be cleared for pregnancy before being considered.

iii. The carrier should not be used when any of the following findings are present:

1. Physical evidence for risk of sexually transmitted disease, such as genital ulcerative lesions, herpes simplex, chancroid, and urethral discharge
2. Physical evidence of risk for syphilis or evidence of syphilis
3. Physical evidence of nonmedical percutaneous drug use, such as needle tracks; the examination should include examination of tattoos, which might obscure needle tracks
4. Physical evidence of recent tattooing, ear piercing, or body piercing (within the past 12 months) where sterile technique was not used

5. Disseminated lymphadenopathy
6. Unexplained oral thrush
7. Blue or purple spots consistent with Kaposi sarcoma
8. Unexplained jaundice, hepatomegaly, or icterus
9. Large scab consistent with recent history of smallpox immunization
10. Eczema vaccinatum, generalized vesicular rash, severely necrotic lesion (consistent with vaccinia necrosum), or corneal scarring (consistent with vaccinial keratitis)

iv. Laboratory testing

There is no method to completely ensure that the carrier will not have infectious agents that could be transmitted to the fetus. However, the following guidelines, combined with an adequate medical history and specific exclusion of individuals at high risk for HIV and other STIs, should dramatically reduce these risks. The ASRM recommends the following tests be performed on the carrier and her partner and that negative results be documented before use of the gestational carrier.

1. Carrier and her sexually intimate partner
   a. HIV-1 antibody as well as NAT
   b. HIV-2 antibody
   c. HIV group O antibody
   d. HTLV-1 and HTLV-2 (male partner only)
   e. Hepatitis C antibody and NAT
   f. Hepatitis B surface antigen
   g. Hepatitis B core antibody (IgG and IgM)
   h. Serologic test for syphilis
   i. CMV (IgG and IgM)
   j. *N. gonorrhoeae* and *C. trachomatis* testing using NAT on urine or a cervical or urethral swab using an FDA-licensed, -approved, or -cleared test labeled for the detection of these organisms in an asymptomatic, low-prevalence population
2. Carrier only
   a. Blood type and Rh factor. If there is the potential for Rh incompatibility, couples should be informed about the obstetric significance of this condition.
   b. Papanicolaou smear
   c. Mammogram according to American College of Obstetricians and Gynecologists guidelines
   d. Titers for varicella and rubella
   e. Urine drug screen

v. Managing laboratory results

1. A positive test should be confirmed before notifying the individual. If a test is confirmed positive, the individual should be referred for appropriate counseling and management.
2. Individuals who test positive for HIV-1, HIV-2, HIV group O antibody, hepatitis B, or hepatitis C should generally not be allowed to serve as gestational carriers. Exceptions to this recommendation require careful counseling, informed consent, and documentation of risks in the medical records.
3. Individuals found to be positive for syphilis, *N. gonorrhoeae*, or *C. trachomatis* should be treated, retested, and deferred from use as a gestational carrier for 12 months after documentation that treatment was successful before being reconsidered. If evidence is presented documenting successful treatment more than 12 months prior, no further deferral is needed as long as current testing does not indicate an active infection.
4. Individuals with false-positive results for syphilis using non-treponemal assays that are confirmed to be negative using a treponemal-based assay are eligible to be used as gestational carriers.
5. Women or their partners who test positive for active infection with CMV (positive urine or throat culture or paired serum samples demonstrating a 4-fold rise in IgG antibody and IgM antibody at least 30% of the IgG level) should be excluded from serving as a carrier until signs of active infection are no longer present.

vi. Legal issues and informed consent

a. Gestational carriers and their partners/spouses should be advised explicitly of the risks of the procedures and medications as well as potential complications of pregnancy, including the possibility of prolonged bed rest or hospitalization. This counseling should be documented in the patients' permanent medical record.
b. Gestational carriers must have ongoing independent legal representation by an appropriately qualified legal practitioner who is experienced with gestational carrier contracts and who is licensed in the relevant state or states, or in the event of an international arrangement, in addition to any relevant states, the intended parent(s)' home country.
c. Special consideration should be given to transferring a single embryo in an effort to limit the risks of multiple pregnancy for the carrier. After appropriate counseling and agreement by all parties, additional embryos may be transferred based on the age of the genetic parent, in an effort to improve the probability of pregnancy.
d. Protection of confidentiality: Individuals participating in gestational carrier programs should be assured that their confidentiality and medical/psychological information will be protected insofar as federal and local statutes permit.

e. Issues regarding screening and testing of the fetus during pregnancy should be discussed and the discussion documented in the medical record or legal contract between the carrier and the intended parents. Contingency plans for management of specific complications (i.e., abnormal genetic testing of the fetus, birth defects, etc.) should be discussed and agreed upon in advance of treatment. The possibility of pregnancy termination for pregnancy complications (in the gestational carrier or fetus) or for multifetal gestations also should be discussed before treatment.

f. Behavior of the gestational carrier: Individuals who smoke, consume alcohol (>1 drink per day), or have other potentially harmful habits should not be considered as gestational carriers. Activity of the carrier (travel, exercise, diet, sexual activity, vitamin supplements, etc.) should be discussed between the parties and agreed upon in advance of treatment.

g. Compensation to the gestational carrier: Compensation to the gestational carrier should be agreed upon in writing in the legal contract between the intended parents and carrier before any treatment begins. The amount of compensation paid to the carrier can be prorated based on the procedure(s) performed.

vii. Quarantining of embryos

All potential gestational carriers should be offered the option of cryopreserving and quarantining embryos derived from the intended parents for 6 months, with release of embryos only after the intended parents have been retested with confirmed negative results (see section on Laboratory testing of gestational carriers, 3.b.iv.1.a-j.). In the event of seroconversion of an intended parent after cryopreservation of the embryos, the ASRM recommends that the embryos should not be transferred into a gestational carrier.

viii. Record keeping

A permanent record of each gestational carrier's initial selection process, medical evaluation, eligibility, and subsequent follow-up evaluations should be maintained indefinitely. The clinical outcome for each cycle should be recorded. A mechanism must exist to maintain such records as a future medical resource for any offspring produced.

4. Psychosocial consultation for gestational carriers and intended parents

a. Psychosocial consultation for intended parents includes:

i. A clinical interview and psychological assessment including the intended parent(s)' history of infertility and methods of coping

ii. Psychological evaluation of each intended parent is strongly recommended as a means to alert the team to significant psychological issues that could compromise successful collaboration with the gestational carrier

iii. Informing intended parent(s) of potential psychological issues and risks associated with the gestational carrier process

iv. Discussion of the medical protocol, scheduling demands, risks of cancelled cycles or unsuccessful cycles, number of embryos transferred, multiple pregnancy, multifetal pregnancy reduction, prenatal diagnostic testing, and elective termination

v. Requirement of intended parent(s)' agreement with the gestational carrier regarding all medical issues

vi. Definition of the role/function of qualified mental health professionals

vii. Counseling topics include:

1. Management during pregnancy of expectations and relationship with the gestational carrier and her family
2. Meeting the emotional and physical needs of the gestational carrier and her family
3. Understanding the gestational carrier's right to make choices for her body over the rights of the intended parents
4. Rights of the gestational carrier to refuse or to accept medical interventions or testing
5. Number of embryos to be transferred and number of cycles planned to be determined by the gestational carrier and physician
6. Multiple pregnancy and associated risks
7. Multifetal pregnancy reduction and discussion of psychological risks and concerns
8. Possibility of abortion in the event of an abnormal fetus
9. Gestational carrier's behavior during pregnancy and methods for resolving conflicts (e.g., eating habits, prescription drugs, alcohol)
10. Disclosure to offspring
11. Disclosure to family members and friends
12. Expectations of relationship between gestational carrier, intended parent(s), and children after birth
13. Need for gestational carrier and her children to interact with baby after birth
14. Disposition of extra embryos
15. Need for separate legal consultation and a written contract
16. Potential guilt reaction of gestational carrier associated with failed attempts or problems that may arise
17. Matching of gestational carrier and intended parent(s)
18. Relationship issues, expectations, and impact of failed cycle

b. Criteria for rejection of intended parents
    i. Absolute criteria for rejection include:
        1. Inability to maintain respectful and caring relationship with gestational carrier
        2. Abnormal psychological evaluation as determined by the qualified mental health professional
        3. Unresolved or untreated addiction, child abuse, sexual or physical abuse, depression, eating disorder
        4. Unresolved or untreated major depression, bipolar disorder, psychosis, or significant anxiety disorder or personality disorder
        5. Current marital or relationship instability
        6. Intended parent(s)' failure to agree with gestational carrier's decision on number of embryos transferred
    ii. Relative criteria for rejection include:
        1. Ongoing legal disputes
        2. Significant and ongoing problematic interpersonal relationships
        3. History of noncompliance or ongoing problematic interactions with program or medical staff
c. Psychosocial consultation for gestational carriers includes:
    i. Informing the potential gestational carrier and her partner regarding the potential psychological issues and risks associated with the process
    ii. Discussion of the medical protocol, including scheduling demands, risks of cancelled cycle and unsuccessful cycle, multiple pregnancy, multifetal pregnancy reduction, prenatal diagnostic testing, and elective termination
    iii. Discussion of requirement of intended parent(s)' agreement with gestational carrier regarding all medical issues
    iv. Definition of role/function of the qualified mental health professional
    v. Counseling topics include:
        1. Management of the relationship between the intended parent(s) and the gestational carrier; past, present, and future
        2. Coping appropriately with the pregnancy
        3. Risks of attachment to the child and risk to the gestational carrier's children
        4. Impact on gestational carrier's marriage or partnership
        5. Impact on gestational carrier's employment
        6. The balance between the gestational carrier's right to privacy and the intended parent(s)' right to information
    vi. Offer of group/individual counseling with qualified mental health professional
    vii. Separate, ongoing legal counsel and representation for gestational carrier and intended parents
    viii. Informing the gestational carrier of source of gametes before legal consent
    ix. Social history, including family of origin
    x. Psychiatric history including prior hospitalizations, suicide attempts, medication, and counseling
    xi. Occupational and financial history
    xii. Sexual and reproductive history
    xiii. History of smoking, substance use, and physical, emotional, or sexual abuse
    xiv. History of postpartum disorder(s) and other unresolved negative reproductive events
    xv. Religious beliefs that may influence behavior
    xvi. Maturity, judgment, assertiveness, and decision-making skills
    xvii. Legal history
    xviii. Negative medical history as it relates to the psychosocial adjustment of being a gestational carrier (e.g., bed rest, gestational diabetes, preeclampsia)
    xix. Personality style and coping skills, capacity for empathy
    xx. Current major life stressors or anticipated changes within the next 2 years
    xxi. Previous gestational carrier experience or application to another facility
    xxii. Motivation to become a gestational carrier
    xxiii. Support of significant other
    xxiv. Social network
    xxv. Desire for more children of her own
    xxvi. Anticipated impact of gestational experience upon her children and significant other
    xxvii. Anticipated type and duration of relationship with intended parents
    xxviii. Ability to separate from and relinquish the child
    xxix. Anticipated feelings toward the child
    xxx. Feelings about multiple pregnancy, bed rest, hospitalization, and pregnancy loss
    xxxi. Feelings about possible sexual abstinence
    xxxii. Feelings and decisions about termination of pregnancy, multifetal pregnancy reduction, amniocentesis, chorionic villi sampling, and other prenatal diagnostic testing
    xxxiii. Reactions to the possibility of becoming infertile as a result of the process
    xxxiv. Agreement with the financial compensation arrangement
d. Criteria for rejection of a gestational carrier
    i. Absolute rejection criteria include:
        1. Cognitive or emotional inability to comply or consent
        2. Evidence of financial or emotional coercion
        3. Abnormal psychological evaluation/testing as determined by the qualified mental health professional
        4. Unresolved or untreated addiction, child abuse, sexual abuse, physical abuse, depression, eating disorders, or traumatic pregnancy, labor and/or delivery

5. History of major depression, bipolar disorder, psychosis, or a significant anxiety disorder
6. Current marital or relationship instability
7. Chaotic lifestyle, current major life stressor(s)
8. Inability to maintain respectful and caring relationship with intended parent(s)
9. Evidence of emotional inability to separate from/surrender the child at birth

ii. Relative rejection criteria include:

1. Failure to exhibit altruistic commitment to become a gestational carrier
2. Problematic personality disorder
3. Insufficient emotional support from partner/spouse or support system
4. Excessively stressful family demands
5. History of conflict with authority
6. Inability to perceive and understand the perspective of others
7. Motivation to use compensation to solve own infertility
8. Unresolved issues with a negative reproductive event

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Recommendations for gamete and embryo donation: a committee opinion

The Practice Committee of the American Society for Reproductive Medicine and the Practice Committee of the Society for Assisted Reproductive Technology

American Society for Reproductive Medicine and Society for Assisted Reproductive Technology, Birmingham, Alabama

This document provides the latest recommendations for evaluation of potential sperm, oocyte, and embryo donors, incorporating recent information about optimal screening and testing for sexually transmitted infections, genetic diseases, and psychological assessments. This revised document incorporates recent information from the U.S. Centers for Disease Control and Prevention, the US Food and Drug Administration, and the American Association of Tissue Banks, with which all programs offering gamete and embryo donation services must be thoroughly familiar, and replaces the document titled, "2008 Guidelines for Gamete and Embryo Donation: A Practice Committee Report," last published in Fertil Steril 2008;90:S30–44. (Fertil Steril® 2013;99:47–62. ©2013 by American Society for Reproductive Medicine.)

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The 2012 Recommendations for Gamete and Embryo Donation provide the latest recommendations for evaluation of potential sperm, oocyte, and embryo donors, incorporating recent information about optimal screening and testing for sexually transmitted infections (STIs), genetic diseases, and psychological assessments. The current document represents an effort to make the screening guidelines for donors of embryos and gametes more consistent and incorporates recent information from the US Centers for Disease Control and Prevention (CDC), US Food and Drug Administration (FDA), and American Association of Tissue Banks (AATB). The risks for transmission of STIs via donations of sperm, oocytes, and embryos differ, and leukocyte-rich semen donation poses unique risks that are reflected in the recommendations.

These guidelines use terminology from the federal agencies in addition to the AATB. In that context, the term "screening" refers to specific historical factors that place an individual at a higher risk for a given disease, such as human immunodeficiency virus (HIV), transmissible spongiform encephalopathy (TSE), or Creutzfeldt-Jakob disease (CJD). "Testing" refers to specific laboratory studies such as serologic tests. The distinction between screening and testing is consistent within the document.

These guidelines for the screening and testing of gamete and embryo donors apply to potential donors in the United States. Because the prevalence of STIs and genetic diseases may vary in other locales, these guidelines may not be appropriate for other countries or individuals who come to the United States from other countries. Whereas the FDA does not require screening or testing of the recipients of donated gametes, the American Society for Reproductive Medicine (ASRM) recommends testing of recipients as described. Other areas where the ASRM recommendations may be more stringent than the FDA minimum requirements are noted in the text. Additionally, state requirements may be more restrictive than the FDA, and clinics are encouraged to check with government officials in the state where their practice is located to determine minimum screening and testing requirements for their state.

The promulgation of FDA regulations has added considerable oversight to gamete and embryo donation, including mandatory registration of all assisted reproductive technology (ART) programs with the federal government, federal inspections of programs that are performing donation, required documentation, and written

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protocols attendant to donor screening, testing, selection, rejection, and follow-up. Complete records of all donor cycles, including documentation of adherence to FDA regulations, must be made available to FDA inspectors at their request. Federal regulations may be viewed at the following Web sites:

http://www.fda.gov/cber/tiss.htm
http://www.fda.gov/BiologicsBloodVaccines/default.htm
http://www.fda.gov/cber/rules/gtp.pdf

GUIDELINES FOR SPERM DONATION

I. Introduction

Therapeutic donor insemination (TDI) may be used to achieve pregnancy where appropriate indications exist. The clinical procedures should take into account the age and health status of the recipient. The FDA has published requirements for the screening and testing of donors of human cells, tissues, and cellular and tissue-based products (HCT/Ps), which are included here. These are the minimum requirements mandated by the federal government. In some instances, the federal requirements may be less rigorous than those in the state in which an individual practice is located or than those recommended by ASRM and the Society for Assisted Reproductive Technology (SART). It is the responsibility of all clinics to know the regulations of their individual states and local municipalities and to comply with those standards.

II. Indications for TDI

A. The male partner has azoospermia, severe oligozoospermia, or other significant sperm or seminal fluid abnormalities.
B. The male partner has ejaculatory dysfunction.
C. The male partner demonstrates significant male factor infertility (i.e., significant oligoasthenospermia or prior failure to fertilize after insemination in vitro and intracytoplasmic sperm injection [ICSI] is not elected or feasible).
D. The male partner has a significant genetic defect or the couple previously has produced an offspring affected by a condition for which carrier status cannot be determined.
E. The male partner has a sexually transmissible infection that cannot be eradicated.
F. The female partner is Rh-negative and severely Rh-isoimmunized and the male partner is Rh-positive.
G. Females without male partners.

III. Psychological consultation for recipients

The decision to proceed with donor insemination is complex, and patients and their partners (if applicable) may benefit from psychological counseling to aid in this decision. The clinician should strongly recommend psychological counseling by a qualified mental health professional to all donor sperm recipients and their partners. The assessment should include a clinical interview and, where appropriate, psychological testing. The clinician should require psychological consultation for couples in whom factors appear to warrant further evaluation. In cases of directed donation, the potential impact of the relationship between the donor and recipient should be explored, as well as any plans that may exist relating to disclosure and future contact.

IV. Evaluation of the partner

A. The partner in any couple that requests TDI should have completed an appropriate clinical evaluation. Medical records should be reviewed before performing the insemination procedure. If appropriate, alternative treatments should be discussed with the couple. While not required by the FDA, infectious disease testing of the male partner is recommended by the ASRM to address any potential medical/legal issues that could arise should the partner seroconvert during or after TDI.
B. Human immunodeficiency virus (HIV-1 antibody [AB] and nucleic acid testing [NAT]), HIV-2 AB testing and screening, or testing for HIV group O antibodies on the male partner is strongly recommended. If the male partner is HIV infected, he should be referred to an appropriate infectious disease specialist for counseling on safe sex practices for preventing HIV transmission, on treatment options, and on other issues concerning HIV disease. A positive HIV test result for the male partner should not be used as an exclusionary criterion for treatment of a couple with TDI.
C. Testing for other STIs similar to that recommended for the female partner (detailed in section V) is encouraged. This includes:
   1. Serologic test for syphilis.
   2. Hepatitis B surface antigen.
   3. Hepatitis B core antibody (IgG and IgM).
   4. Hepatitis C antibody and NAT.
   5. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* NAT on urine or a swab obtained from the urethral meatus.

   Note: There are no FDA-licensed, approved, or cleared tests for donor screening of these organisms in an asymptomatic, low-prevalence population. Tests using NAT technology adequately and appropriately reduce the risk of transmission of these relevant communicable agents.
   6. Human T-cell lymphotropic virus (HTLV) type I and II also may be obtained at the discretion of the clinician in the appropriate clinical setting.

V. Evaluation of the female recipient

A. Routine medical and reproductive history should be obtained according to the standards that are applied to women anticipating pregnancy. Abnormalities detected from history or physical examination may require more detailed evaluation and treatment before proceeding with insemination.
B. A complete general physical examination should be performed, including a pelvic examination.
C. Standard preconceptional screening, testing, and counseling:
   1. Although there are no federal requirements for testing donor sperm recipients, the following tests are recommended:
      a. Blood type, Rh factor, and antibody screen.

b. Rubella and varicella titers. Vaccination should be offered if the individual is not immune to either virus.
c. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* NAT on urine or a swab obtained from the cervix, urethral meatus, or vagina.
d. HIV-1 (AB and NAT), HIV-2 AB testing, and testing or screening for HIV group O antibodies should be performed to address potential medical/legal complications that could arise if the recipient seroconverts during or after treatment. In addition, if the female recipient is found to be HIV-infected before treatment, she should be referred to an appropriate infectious disease specialist for counseling on issues concerning HIV disease, including reproductive issues such as safe sex practices for preventing HIV transmission to uninfected partners and treatment options to reduce the probability of transmission to her child. A positive HIV test of the female recipient should not be used as an exclusionary criterion for treatment with TDI as long as the couple makes an informed decision after counseling and agrees to comply with recommended clinical management for the positive HIV status during pregnancy.
e. Serologic test for syphilis.
f. Hepatitis B surface antigen.
g. Hepatitis B core antibody (IgG and IgM).
h. Hepatitis C antibody and NAT.
i. Cytomegalovirus (CMV) antibody (IgG and IgM). For women who test positive for active infection (positive urine or throat culture or paired serum samples demonstrating a four-fold rise in IgG antibody and IgM antibody at least 30% of the IgG level), attempts to conceive should be postponed until they no longer exhibit active infection, owing to the risk of transmitting the infection to their fetus and the serious potential consequences of fetal CMV infection.
j. HTLV type I and II also may be obtained at the discretion of the clinician in the appropriate clinical setting.

D. Documentation and timing of ovulation
1. Women with regular cyclic menses and molimina are assumed to be ovulating. When doubt exists, an index of ovulation, such as serum progesterone level, basal body temperature recordings, LH surge detection, and ultrasound monitoring of follicular maturation, may be used to document ovulation. Appropriate timing of the insemination procedure optimizes chances for success.

E. Evaluation for possible tubal or peritoneal abnormalities

F. Patients who fail to conceive after 4 to 6 well-timed inseminations may be candidates for hysterosalpingography (HSG), laparoscopy, or other appropriate tests to detect possible causes for their failure to conceive. Pretreatment HSG or laparoscopy may be indicated by the history and/or physical findings.

G. Informed consent should be obtained from the patient (and her partner, if applicable).

VI. Donors

A. Selection of donor
1. The main qualities to seek in selecting a donor for TDI are an assurance of good health status and the absence of known genetic abnormalities.
2. The donor should be of legal age and, ideally, less than 40 years of age.
3. Selection of donors with established fertility is desirable but not required.
4. Psychological evaluation and counseling by a qualified mental health professional is strongly recommended for all sperm donors. The assessment should include a clinical interview and, where appropriate, psychological testing. Psychological consultation should be required for individuals in whom there appear to be factors that warrant further evaluation. In cases of directed donation, psychological evaluation and counseling are strongly recommended for the donor and his partner (if applicable) as well as for the recipient female and her partner (if applicable). The potential impact of the relationship between the donor and recipient should be explored. The psychological assessment also should address the potential psychological risks and evaluate for evidence of coercion (financial or emotional). It is important to ascertain whether the donor is well informed about the extent to which information about him might be disclosed and about any plans that may exist relating to future contact.
5. No owner, operator, laboratory director, or employee of a facility performing TDI may serve as a donor in that practice.
6. Neither the patient's physician nor the individual performing the actual insemination can be the sperm donor.

B. Screening and testing of donors
1. Semen testing
a. It is suggested that more than one sample be examined (each after a 2- to 5-day abstinence interval) before proceeding with a more extensive evaluation of the donor candidate.
b. The sample should be examined within 1 to 2 hours after ejaculation into a sterile container. The criteria used to judge the normality of the sample can vary among laboratories. There are no uniformly accepted standards, but, in general, the minimum criteria for normal semen quality can be applied (1).
2. Genetic evaluation
Genetic screening for heritable diseases should be performed in potential sperm donors. Testing for cystic fibrosis carrier status should be performed on all donors. Other genetic testing should be performed as indicated by the donor's ethnic

background in accordance with current recommendations after obtaining a proper family history. Chromosomal analyses on all sperm donors are not required (see Appendix A for further details regarding genetic screening and testing) (2–4).

3. Medical history
   a. Donors should be healthy and give no history to suggest hereditary disease.
   b. A complete personal and sexual history should be obtained to exclude as donors individuals who might be at high risk for HIV, STIs, or other infections that might be transmissible via gamete donation. Prospective sperm donors with any of the following factors should not be accepted (for a complete list of screening questions, see "Uniform Donor Application" at www.sart.org):
      i. Men with a history of sex with another man in the preceding 5 years.
      ii. Men who have injected drugs for nonmedical reasons in the preceding 5 years, including intravenous, intramuscular, and subcutaneous injections.
      iii. Men with hemophilia or other related clotting disorders who have received human-derived clotting factor concentrates in the preceding 5 years.
      iv. Men who received clotting factors once to treat an acute bleeding event more than 12 months ago may be eligible to donate.
      v. Men who have had sex in exchange for money or drugs in the preceding 5 years.
      vi. Men who have had sex in the preceding 12 months with any person meeting any of the criteria described immediately above, or with any person having HIV infection, including a positive or reactive test to HIV virus, hepatitis B infection, or clinically active (symptomatic) hepatitis C infection.
      vii. Men who have been exposed within the last 12 months through percutaneous inoculation or contact with an open wound, nonintact skin, or mucous membrane to blood that is known or suspected to be infected with HIV, hepatitis B, and/or hepatitis C virus.
      viii. Men who have had close contact (e.g., living in the same household wherein sharing of kitchen and bathroom facilities occurs regularly) within 12 months preceding the donation with another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection.
      ix. Men who have been incarcerated in lockup, jail, or prison for more than 72 consecutive hours within the previous 12 months.
      x. Men who have had or have been treated for syphilis, gonorrhea, or chlamydia within the preceding 12 months. Deferral of donors is not necessary when there is evidence of successful treatment more than 12 months before.
      xi. Men who have undergone body piercing and/or tattooing procedures within the preceding 12 months in which sterile procedures were not used or it is unclear whether sterile procedures were used (e.g., contaminated instruments and/or ink were used, or shared instruments that had not been sterilized between uses were used).
      xii. Men who have received a smallpox vaccination (vaccinia virus) for 21 days after vaccination or until the scab separates spontaneously and physical examination confirms the absence of a scab at the vaccination site (whichever is later). The donor should be deferred for 2 months if the scab was removed before spontaneous separation. If the donor experienced complications from vaccination, he should be deferred until 14 days after complete resolution of those complications. If the donor became infected as a result of close contact with a person recently vaccinated for vaccinia, he may be considered eligible for donation if the scab spontaneously separated, if 14 days have elapsed since resolution of all the vaccinia-related complications, or 3 months after the scab was otherwise removed.
      xiii. Men who have had a medical diagnosis or suspicion of West Nile virus (WNV) infection (based on symptoms and/or laboratory results or confirmed WNV viremia) should be deferred for 120 days after the onset of symptoms or diagnosis, whichever is later.
      xiv. Men who have tested positive or reactive for WNV infection using an FDA-licensed or investigational WNV NAT in the preceding 120 days.
      xv. Men who have been diagnosed with variant CJD (vCJD) or any other form of CJD.
      xvi. Men who have been diagnosed with dementia or any other degenerative or demyelinating disease of the central nervous system or other neurologic disease of unknown etiology. Potential donors who have a diagnosis of delirium (e.g., delirium caused by toxic/metabolic diseases or recent head trauma) would not be considered necessarily to have a diagnosis of dementia and should be evaluated by the medical director.

xvii. Men who are at increased risk for CJD. Donors are considered to have an increased risk for CJD if they have received a non-synthetic dura mater transplant, human pituitary-derived growth hormone, or have one or more blood relatives diagnosed with CJD.

xviii. Men who have a history of CJD in a blood relative unless: the diagnosis of CJD was subsequently found to be in error, the CJD was iatrogenic, or laboratory testing (gene sequencing) demonstrates that the donor does not have a mutation associated with familial CJD.

xix. Men who spent 3 months or more cumulatively in the United Kingdom (U.K.) from the beginning of 1980 through the end of 1996.

xx. Men who are current or former US military members, civilian military employees, or dependants of a military member or civilian employee who resided at US military bases in Northern Europe (Germany, Belgium, and the Netherlands) for 6 months or more cumulatively from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more cumulatively from 1980 through 1996.

xxi. Men who spent 5 years or more cumulatively in Europe from 1980 until present.

xxii. Men who received any transfusion of blood or blood components in the United Kingdom or France between 1980 and the present.

xxiii. Men or their sexual partners who were born or lived in certain countries in Africa (Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria) after 1977 (risk factor for HIV group O).

xxiv. Men who have received a blood transfusion or any medical treatment that involved blood in the countries listed in xxiii after 1977 (risk factor for HIV group O).

Note: Establishments using an HIV-1/2 antibody donor screening test that has been licensed by the FDA and is specifically labeled in the Intended Use section of the package insert as sensitive for the detection of HIV group O antibodies may delete items VI.B.3.b.xxiii and xxiv from their screening procedures. If screening questions VI.B.3.b.xxiii and xxiv also are asked, donor eligibility may be based on the donor test results, regardless of the answers to those two questions.

xxv. Men who have received xenotransplants (live cells, tissues, or organs from a nonhuman animal source or human body fluids, cells, tissues, or organs that have had ex vivo contact with live nonhuman animal cells, tissues, or organs) or have been in close contact with a xenotransplant recipient.

xxvi. Men who have received human organ or tissue transplants or treatment with human extracts.

4. Physical examination
   a. Before acceptance, and every 6 months while remaining an active donor, donors should undergo a complete physical examination and should be declined when any of the following findings are present (see www.sart.org Male Donor Physical Examination Form):
      i. Physical evidence for risk of sexually transmitted disease such as genital ulcerative lesions, herpes simplex, chancroid, or urethral discharge.
      ii. Physical evidence for risk of, or evidence of, syphilis.
      iii. Physical evidence of anal intercourse including perianal condylomata.
      iv. Physical evidence of non-medical percutaneous drug use such as needle tracks; the examination should include examination of tattoos, which might be covering needle tracks.
      v. Physical evidence of recent (within 12 months) tattooing, ear piercing, or body piercing where sterile technique was not used.
      vi. Disseminated lymphadenopathy.
      vii. Unexplained oral thrush.
      viii. Blue or purple spots consistent with Kaposi sarcoma.
      ix. Unexplained jaundice, hepatomegaly, or icterus.
      x. Large scab consistent with recent history of smallpox immunization.
      xi. Eczema vaccinatum, generalized vesicular rash, severely necrotic lesion (consistent with vaccinia necrosum), or corneal scarring (consistent with vaccinial keratitis).
5. Laboratory testing

   There is no method to ensure completely that infectious agents will not be transmitted by TDI. However, the following guidelines, combined with an adequate history and specific exclusion of individuals at high risk for HIV and other STIs, should significantly reduce these risks. The FDA requires that the following tests be performed, using methods required for purposes of determining donor eligibility, and that negative results are documented before use of the donor's sperm. The list of test methods approved by the FDA for this purpose is available at the following Web sites:

   http://www.fda.gov/cber/products/testkits.htm

http://www.fda.gov/downloads/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Guidances/Tissue/ucm091345.pdf

Clinics using donor sperm from a commercial sperm bank should have documentation from the bank that they adhere to federal and local requirements (5).

a. HIV-1 antibody as well as NAT.
b. HIV-2 antibody.
c. HIV group O antibody. Establishments that do not use an FDA-licensed test for HIV group O antibodies must evaluate donors for risk associated with HIV group O infection with additional screening questions as described in VI.B.3.b.x-xiii and xxiv.
d. Hepatitis C antibody and NAT.
e. Hepatitis B surface antigen.
f. Hepatitis B core antibody (IgG and IgM).
g. Serologic test for syphilis.
h. HTLV-1 and HTLV-2.
i. CMV (IgG and IgM). Men who test positive for active infection (positive urine or throat culture or paired serum samples demonstrating a four-fold rise in IgG antibody and IgM antibody at least 30% of the IgG level) should be excluded. Because CMV is so common, insemination with semen from a CMV-seropositive man (without active infection) is permissible when the female partner is also CMV seropositive. Although the practice is not entirely without risk, because there are many strains of CMV and superinfection is possible, the associated risk of newborn CMV infection is approximately 1%, and such infants appear to have no significant illness or other abnormality.
j. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* NAT on urine or a swab obtained from the urethral meatus. These tests should be repeated if clinically indicated. Retesting of the donor at 6-month intervals is required as long as the donor remains active.

   N.B. There are no FDA-licensed, approved or cleared tests for donor screening of these organisms in an asymptomatic, low-prevalence population. Tests using NAT technology adequately and appropriately reduce the risk of transmission of these relevant communicable agents.
k. Donors found to be positive for syphilis, *Neisseria gonorrhoeae*, or *Chlamydia trachomatis* should be treated, retested, and deferred from donation for 12 months after documentation that treatment was successful before being reconsidered. If evidence is presented that treatment occurred more than 12 months ago and was successful, no further deferral is needed as long as current testing does not indicate an active infection.
l. Abbreviated donor screening documenting no change in the donor's medical and/or social history should be performed at 6-month intervals.
m. Additional testing should be performed as dictated by local or state requirements.
n. Additional testing not required by the FDA but recommended by the ASRM includes blood type and Rh. If the use of donor oocytes creates the potential for Rh incompatibility, couples should be informed about obstetric significance of this condition.

6. Managing laboratory results
   a. If testing is negative, semen samples may be collected and prepared for cryopreservation.
   b. A positive test should be verified before notifying the potential donor. If a test is confirmed positive, the individual should be referred for appropriate counseling and management.
   c. Individuals who initially test positive (except for treated syphilis, *Neisseria gonorrhoeae*, or *Chlamydia trachomatis* as described earlier) are not eligible for anonymous donation.
   d. False-positive results for syphilis using non-treponemal assays that are confirmed to be negative using a treponemal-based assay are eligible for donation.
   e. After donation, anonymous donor specimens must be quarantined for a minimum of 180 days. The donor must be retested (see section VI.B.5) after the required quarantine interval, and specimens may be released only if the results of repeat testing are negative.
   f. Screening and testing of donors for STIs and genetic risk factors may change over time as tests improve and new tests become available. Therefore, samples of sperm that are cryopreserved and stored for periods of time may not meet existing testing standards at the time they are released for use. In such instances, every effort should be made to have the donor tested in accordance with current standards. In situations where the donor is not available or refuses such additional testing, the sample(s) may be released provided that the recipient is informed that the specimen does not meet current screening and testing guidelines, is informed of what tests have not been performed, and is counseled regarding the clinical implications of the missing information.
7. Directed donation

   Directed (non-anonymous or known) donation is acceptable if all parties agree. Directed donors must undergo the same screening and testing as anonymous donors. Directed donors who test positive or demonstrate a risk factor for a relevant communicable disease are not prohibited from use according to current FDA rules, provided that the tissue is labeled to indicate any associated increased

risks and that physicians using samples are aware of the status of the results. Although the FDA does not require informing the recipients of the test results, in the opinion of the ASRM the recipients must be informed and counseled appropriately before use of the samples. Directed donor specimens also are exempt from quarantine under the current FDA guidelines, which require only retesting as described earlier (see section VI.B.5) within 7 days before donation. However, in the opinion of the ASRM, directed donor specimens should be treated in the same manner as anonymous donor specimens; results of testing that would exclude an anonymous donor also should exclude a directed donor, and directed donor specimens should be quarantined and released in the same manner required for anonymous donor specimens (see sections VI.B.1–6).

8. Use of fresh semen
   In the opinion of the ASRM, the use of fresh semen can be justified only for sexually intimate couples. It is possible for HIV and other infectious organisms to be transmitted by fresh donor semen before the donor has become seropositive. Consequently, the potential for transmission of infections by fresh semen cannot be eliminated. The ASRM recommends that all directed donor specimens be frozen and quarantined for a minimum of 180 days, with the donor then retested as described above (see section VI.B.5) and demonstrated seronegative before the specimen is released.

C. Management of donors
   1. Monitoring health status
      The single most important method for reducing the risk of transmitting infectious agents to women during insemination is to screen carefully and test the potential donors and to develop an ongoing procedure for monitoring their health status.
   2. Payment to donors
      Payment to donors varies from area to area but should not be such that the monetary incentive is the primary motivation for donating sperm. However, the donor may be compensated for his time and expenses.
   3. Limitations to donor use
      Institutions, clinics, and sperm banks should maintain sufficient records to allow a limit to be set for the number of pregnancies for which a given donor is responsible. It is difficult to provide a precise number of times that a given donor can be used because one must take into consideration the population base from which the donor is selected and the geographic area that may be served by a given donor. It has been suggested that in a population of 800,000, limiting a single donor to no more than 25 births would avoid any significant increased risk of inadvertent consanguineous conception. This suggestion may require modification if the population using donor insemination represents an isolated subgroup or if the specimens are distributed over a wide geographic area.
   4. Consent
      It is essential for the donor to sign a consent form, which should include a firm denial of having any recognized risk factors for STIs and genetic diseases. It is recommended that the donor acknowledge in the consent form his responsibility to notify the donor program of any changes in his health or risk factor status.
   5. Record keeping
      The FDA requires that records pertaining to each donor (screening and test results) be maintained for at least 10 years. However, in the opinion of the ASRM, a permanent record of each donor's initial selection process and subsequent follow-up evaluations should be maintained. Ideally, the clinical outcome of each insemination cycle should be recorded as well as a mechanism for reporting any adverse outcomes including heritable diseases identified preconceptually or post natally. In the event that a previously unidentified heritable disease is encountered in a child produced from anonymous donation, the donor as well as the recipient of the donated sperm should be tested and further release of samples from the donor should be prohibited. If the donor is found to be the carrier for the heritable disease, all recipients of that donated sperm as well as the clinics performing the procedures should be notified and counseled. A mechanism must exist to maintain records on the donor as a future medical resource for any offspring produced.
   6. Protection of confidentiality
      Individuals participating in donor programs should be assured that their confidentiality will be protected insofar as federal and local statutes permit. Medical records detailing the donation should be maintained as stipulated by federal and local requirements.

VII. Choosing donor characteristics
   There are several methods for matching the male partner with the donor. The couple should be encouraged to list the characteristics that they desire in a prospective donor, including race and/or ethnic group, height, body build, complexion, eye color, and hair color and texture. Consideration should be given to blood type and Rh factor, particularly for Rh-negative recipients. If the use of donor sperm creates the potential for Rh incompatibility, recipients should be informed of the obstetric implications of the condition.

GUIDELINES FOR OOCYTE DONATION

I. Introduction
   Oocyte donation requires ovarian stimulation with monitoring and oocyte retrieval, involving significant inconvenience, discomfort, and risks for the donor.

II. Indications for use of donor oocytes
   A. Women with hypergonadotropic hypogonadism.
   B. Women of advanced reproductive age.

C. Women who have diminished ovarian reserve.
D. Women who are known to be affected by or known to be the carrier of a significant genetic defect or who have a family history of a condition for which carrier status cannot be determined.
E. Women with poor oocyte and/or embryo quality or multiple previous failed attempts to conceive via ART.

III. Psychological consultation for oocyte donor recipients
The decision to proceed with donated oocytes is complex, and patients and their partners (if applicable) may benefit from psychological counseling to aid in this decision. The clinician should strongly recommend psychological counseling by a qualified mental health professional to all donor oocyte recipients and their partners. The assessment should include a clinical interview and, where appropriate, psychological testing. The clinician should require psychological consultation for couples in whom there appear to be factors that warrant further evaluation. In cases of directed donation, the potential impact of the relationship between the donor and recipient should be explored, as well as any plans that may exist relating to disclosure and future contact.

IV. Evaluation of the oocyte recipient
A. Medical and reproductive history
1. Routine medical and reproductive histories should be obtained according to the standards that are applied to women anticipating pregnancy. Reproductive abnormalities detected from history or physical examination may require more detailed evaluation and treatment before donor oocytes are used.
B. A complete general physical examination should be performed, including a pelvic examination.
C. Assessment of the uterine cavity
1. HSG, saline infusion ultrasonography, or another suitable procedure should be performed to detect any significant uterine abnormality.
D. Standard preconceptional testing and counseling
1. Although there are no federal requirements for testing oocyte recipients, the following tests are recommended:
a. Blood type, Rh factor, and antibody screen.
b. Rubella and varicella titers. Recipients should be offered immunization if not immune.
c. HIV-1 (AB and NAT), HIV-2 AB testing and screening or testing for HIV group O antibodies. HIV testing should be performed to address potential medical/legal complications that could arise if the recipient seroconverts during or after treatment. In addition, if the female recipient is found to be HIV infected before treatment, she should be referred to an appropriate infectious disease specialist for counseling on issues concerning HIV disease, including reproductive issues such as safe sex practices for preventing HIV transmission to uninfected partners and treatment options to reduce the probability of transmission to her child; counseling should be documented in the medical record. A positive HIV test of the female recipient should not be used as an exclusionary criterion for treatment, provided that the couple makes an informed decision after counseling and agrees to comply with recommended clinical management for the positive HIV state.
d. Serologic test for syphilis.
e. Hepatitis B surface antigen.
f. Hepatitis B core antibody (IgG and IgM).
g. Hepatitis C antibody and NAT.
h. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* NAT on urine or a swab obtained from the cervix, urethral meatus, or vagina.

V. Evaluation of the partner of the oocyte recipient
A. Laboratory tests. Although there are no federal requirements for testing the partner of the oocyte recipient, the following tests are recommended:
1. Semen analysis for male partners.
2. Blood type and Rh factor.
3. Serologic test for syphilis.
4. Hepatitis B surface antigen.
5. Hepatitis B core antibody (IgG and IgM).
6. Hepatitis C antibody and NAT.
7. HIV-1 (AB and NAT), HIV-2 AB testing and screening, or testing for HIV group O antibodies. HIV testing should be performed to address potential medical/legal complications that could arise if the recipient seroconverts during or after treatment. In addition, if the partner is found to be HIV infected before treatment, he should be referred to an appropriate infectious disease specialist for counseling on issues concerning HIV disease, including reproductive issues such as safe sex practices for preventing HIV transmission to uninfected partners. Counseling should be documented in the medical record. A positive HIV test of the partner should not be used as an exclusionary criterion for treatment.
8. Appropriate genetic screening and testing based on history, in accordance with ethnic background and current recommendations (see Appendix A) (2–4).

VI. Donors
A. Selection of donors
1. Oocyte donation may be undertaken with known or anonymous donors depending on the clinical circumstances.
2. Psychological evaluation and counseling by a qualified mental health professional is strongly recommended for the oocyte donor and her partner (if applicable). The assessment should include a clinical interview and, where appropriate, psychological testing. Psychological consultation should be required for individuals in whom there appear to be factors that warrant further evaluation. In circumstances involving known donors, psychological evaluation and counseling is strongly recommended for the donor and her partner, if applicable, as well as for the recipient and her partner, if applicable. The potential impact of the

relationship between the donor and recipient should be explored. The psychological assessment also should address the potential psychological risks and evaluate for evidence of coercion (financial or emotional). It is important to ascertain whether the donor is well informed about the extent to which information about her may be disclosed and about any plans that may exist relating to future contact.

3. Oocyte donors should be of legal age and preferably between the ages of 21 and 34 years.
4. Donors less than 21 years of age should have psychological evaluation by a qualified mental health professional, and the decision to proceed with such a donor should be determined on an individual basis.
5. If a prospective donor is over 34 years of age, the age of the donor should be revealed to the recipient as part of the informed consent discussion concerning cytogenetic risks and the effect of donor age on pregnancy rates.
6. Proven fertility in the donor is desirable but not required.
7. The donor should undergo appropriate genetic evaluation based on history, in accordance with ethnic background and current guidelines. Cystic fibrosis testing should be performed on all donors. Consideration should be given to fragile X testing on donors, but is not required (see Appendix A) (2–4).
8. Sharing of oocytes from an assisted reproduction cycle: If sharing of oocytes is contemplated, informed consent must be obtained before the start of the cycle of retrieval. The conditions governing the sharing of oocytes should be specified in advance, be included in the informed consent, and comply with existing ASRM Ethics Committee guidelines (6).
9. No owner, operator, laboratory director, or employee of a facility screening for or performing oocyte donation may serve as a donor in that practice.
10. If an agency is used to recruit oocyte donors, no individual who has a financial interest in that agency may be used as an oocyte donor.

B. Screening and testing of oocyte donors

1. Donors should be healthy and give no history to suggest hereditary disease.
2. A complete personal and sexual history should be obtained to exclude as donors individuals who might be at high risk for HIV, STIs, or other infections that might be transmissible via gamete donation. Prospective oocyte donors with any of the following factors should not be accepted (for a complete list of screening questions, see "Uniform Donor Application" at www.sart.org):
   a. Women who have injected drugs for non-medical reasons in the preceding 5 years, including intravenous, intramuscular, and subcutaneous injections.
   b. Women with hemophilia or other related clotting disorders who have received human-derived clotting factor concentrates in the preceding 5 years.
      i. Women who received clotting factors to treat an acute bleeding event more than 12 months prior to planned donation may be eligible to donate.
   c. Women who have had sex with a man who has had sex with another man in the past 5 years.
   d. Women who have had sex in exchange for money or drugs in the preceding 5 years.
   e. Women who have had sex in the preceding 12 months with any person meeting any of the criteria described immediately above, or with any person having HIV infection including a positive or reactive test to HIV virus, hepatitis B infection, or clinically active (symptomatic) hepatitis C infection.
   f. Women who have been exposed within the last 12 months, through percutaneous inoculation or contact with an open wound, non-intact skin, or mucous membrane, to blood that is known or suspected to be infected with HIV, hepatitis B, and/or hepatitis C virus.
   g. Women who have had close contact (e.g., living in the same household wherein sharing of kitchen and bathroom facilities occurs regularly) within 12 months preceding the donation with another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection.
   h. Women who have been incarcerated in lock-up, jail, or prison for more than 72 consecutive hours within the previous 12 months.
   i. Women who have had or have been treated for syphilis, gonorrhea, or chlamydia within the preceding 12 months. Deferral of donors is not necessary if evidence is presented that treatment occurred more than 12 months ago and was successful.
   j. Women who have undergone body piercing and/or tattooing procedures within the preceding 12 months in which sterile procedures were not used or it is unclear whether sterile procedures were used (e.g., contaminated instruments and/or ink were used or shared instruments that had not been sterilized between uses were used).
   k. Women who have received a smallpox vaccination (vaccinia virus) for 21 days after vaccination or until the scab separates spontaneously and physical examination confirms the absence of a scab at the vaccination site (whichever is later). The donor should be deferred for 2 months if the scab was removed before spontaneous separation. If the donor experienced complications from vaccination, she should be deferred until 14 days after complete resolution of those complications. If the donor became infected as

a result of close contact with a person recently vaccinated for vaccinia, she may be considered eligible for donation if the scab spontaneously separated, if 14 days have elapsed since resolution of all the vaccinia-related complications, or 3 months after the scab was otherwise removed.

l. Women who have had a medical diagnosis or suspicion of WNV infection (based on symptoms and/or laboratory results or confirmed WNV viremia) should be deferred for 120 days after the onset of symptoms or diagnosis, whichever is later.
m. Women who have tested positive or reactive for WNV infection using an FDA-licensed or investigational WNV NAT donor-screening test in the preceding 120 days.
n. Women who have been diagnosed with vCJD or any other form of CJD.
o. Women who have been diagnosed with dementia or any other degenerative or demyelinating disease of the central nervous system or other neurologic disease of unknown etiology. Potential donors who have a diagnosis of delirium (e.g., delirium caused by toxic/metabolic diseases or recent head trauma) would not be considered necessarily to have a diagnosis of dementia and should be evaluated by the medical director.
p. Women who are at increased risk for CJD. Donors are considered to have an increased risk for CJD if they have received a non-synthetic dura mater transplant, human pituitary-derived growth hormone, or have one or more blood relatives diagnosed with CJD.
q. Women who have a history of CJD in a blood relative unless the diagnosis of CJD was subsequently found to be in error, the CJD was iatrogenic, or laboratory testing (gene sequencing) demonstrates that the donor does not have a mutation associated with familial CJD.
r. Women who spent 3 months or more cumulatively in the United Kingdom from the beginning of 1980 through the end of 1996.
s. Women who are current or former US military members, civilian military employees, or dependants of a military member or civilian employee who resided at US military bases in Northern Europe (Germany, Belgium, and the Netherlands) for 6 months or more cumulatively from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more cumulatively from 1980 through 1996.
t. Women who spent 5 years or more cumulatively in Europe from 1980 until present.
u. Women who received any transfusion of blood or blood components in the United Kingdom or France between 1980 and the present.
v. Women or their sexual partners who were born or lived in certain countries in Africa (Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria) after 1977 (risk factor for HIV group O).
w. Women who have received a blood transfusion or any medical treatment that involved blood in the countries listed above after 1977 (risk factor for HIV group O).

Note: Establishments using an HIV-1/2 antibody donor screening test that has been licensed by the FDA and is specifically labeled in the Intended Use Section of the package insert as sensitive for the detection of HIV group O antibodies may delete items VI.B.2.v and VI.B.2.w from their screening procedures. If screening questions VI.B.2.v and VI.B.2.w also are asked, donor eligibility may be based on the results of the donor test results regardless of the answers to those two questions.

x. Women who have received xenotransplants (live cells, tissues, or organs from a nonhuman animal source or human body fluids, cells, tissues, or organs that have had ex vivo contact with live nonhuman animal cells, tissues, or organs) or have been in close contact with a xenotransplant recipient.
y. Women who have received human organ or tissue transplants or treatment with human extracts.

3. Before acceptance, and every 6 months while remaining an active donor, donors should undergo a complete physical examination and should be declined when any of the following findings are present (see female donor physical exam at www.sart.org):
   a. Physical evidence for risk of sexually transmitted disease such as genital ulcerative lesions, herpes simplex, chancroid, and urethral discharge.
   b. Physical evidence for risk of or evidence of syphilis.
   c. Physical evidence of anal intercourse including perianal condylomata.
   d. Physical evidence of non-medical percutaneous drug use such as needle tracks; the examination should include examination of tattoos, which might be covering needle tracks.
   e. Physical evidence of recent (within 12 months) tattooing, ear piercing, or body piercing where sterile procedure was not used.
   f. Disseminated lymphadenopathy.
   g. Unexplained oral thrush.
   h. Blue or purple spots consistent with Kaposi sarcoma.
   i. Unexplained jaundice, hepatomegaly, or icterus.
   j. Large scab consistent with recent history of smallpox immunization.
   k. Eczema vaccinatum, generalized vesicular rash, severely necrotic lesion (consistent with vaccinia necrosum), or corneal scarring (consistent with vaccinial keratitis).
4. Laboratory testing

   There is no method to ensure completely that infectious agents will not be transmitted via oocyte donation. However, the following guidelines, combined

with an adequate medical history and specific exclusion of individuals at high risk for HIV and other STIs, should dramatically reduce these risks. The FDA requires that the following tests be performed within 30 days of oocyte collection, using methods required for purposes of determining donor eligibility, and that negative results are documented before use of the donor's oocytes. The list of test methods approved by the FDA for this purpose is available at the following Websites:

http://www.fda.gov/cber/products/testkits.htm

http://www.fda.gov/downloads/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Guidances/Tissue/ucm091345.pdf

a. HIV-1 antibody as well as NAT.
b. HIV-2 antibody.
c. HIV group O antibody. Establishments that do not use an FDA-licensed test for group O antibodies must evaluate donors for risk associated with HIV group O infection as described in VI.B.2.v and w.
d. Hepatitis C antibody and NAT.
e. Hepatitis B surface antigen.
f. Hepatitis B core antibody (IgG and IgM).
g. Serologic test for syphilis.
h. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* NAT on urine or a swab obtained from the cervix, urethral meatus, or vagina.
i. Although not required by the FDA, recommended tests also include blood type and Rh factor. If the use of donor oocytes creates the potential for Rh incompatibility, couples should be informed about the obstetric significance of this condition.

C. Managing laboratory results
1. A positive test should be verified before notifying the potential donor. If a test is confirmed positive, the individual should be referred for appropriate counseling and management.
2. Individuals who initially test positive (except for treated syphilis, *Neisseria gonorrhoeae*, or *Chlamydia trachomatis* as described above) are not eligible for anonymous donation.
3. False positive results for syphilis using nontreponemal assays that are confirmed to be negative using a treponemal-based assay are eligible for donation.
4. Donors found to be positive for syphilis, *Neisseria gonorrhoeae*, or *Chlamydia trachomatis* should be treated, retested, and deferred from donation for 12 months after documentation that treatment was successful before being reconsidered. If evidence is presented that treatment occurred more than 12 months ago and was successful, no further deferral is needed as long as current testing does not indicate an active infection.

D. Quarantining of oocytes
At this time, oocyte freezing cannot be performed reliably; therefore, the quarantining of oocytes is not practical. All potential recipient couples should be offered the option of cryopreserving and quarantining embryos derived from donor oocytes for 180 days, with release of embryos only after the donor has been retested with confirmed negative results (see section VI.B.4). However, couples also should be informed that embryo cryopreservation may significantly reduce implantation rates. The recipient couple should be counseled appropriately in the event of seroconversion of the oocyte donor after cryopreservation of the embryos or if the donor refuses to be retested.

E. Directed donation
Directed (non-anonymous or known) donation is acceptable if all parties agree. Directed donors must undergo the same screening and testing as anonymous donors. Directed donors who test positive or demonstrate a risk factor for a relevant communicable disease are not prohibited from use according to current FDA rules, provided that the tissue is labeled to indicate any associated increased risks and that physicians using samples are aware of the status of the results. Although the FDA does not require informing the recipients of the test results, the ASRM recommends that the recipients must be informed and counseled appropriately before use of the samples. Additionally, the ASRM recommends that directed-donor specimens should be treated in the same manner as anonymous-donor specimens; results of testing that would exclude an anonymous donor also should exclude a directed donor.

F. Payment to the donor
1. Compensation to the donor should be in compliance with the ASRM Ethics Committee report on the subject (7).
2. Monetary compensation of the donor should reflect the time, inconvenience, and physical and emotional demands and risks associated with oocyte donation and should be at a level that minimizes the possibility of undue inducement of donors and the suggestion that payment is for the oocytes themselves.
3. Financial obligations and responsibilities in the event of complications or medical expenses of a donor should be agreed upon contractually before initiation of a stimulation cycle.
4. Payment may be prorated based on the number of steps completed in the procedure.
5. Payment should not be predicated on clinical outcome.

G. Multiple oocyte donations
This subject is addressed specifically in the ASRM Practice Committee Opinion entitled "Repetitive Oocyte Donation" (8).

H. Unintended donor pregnancies
The donor should be counseled about the possibility of unintended pregnancy and offered options for prevention.

I. Age of the recipient
In view of the concerns about pregnancy in women of advanced reproductive age, it is recommended that potential recipients over the age of 45 undergo thorough medical evaluation (including cardiovascular testing) and a high-risk obstetric consultation before undertaking IVF with donor oocytes.

J. Record keeping
The FDA requires that records pertaining to each donor (screening and test results) be maintained for at least 10 years. However, in the opinion of the ASRM, a permanent record of each donor's initial selection process and subsequent follow-up evaluations should be maintained. Ideally, the clinical outcome for each donation cycle should be recorded as well as a mechanism for reporting any adverse outcomes including heritable diseases identified preconceptually or post natally. In the event that a previously unidentified heritable disease is encountered in a child produced from anonymous donation, the donor as well as the recipient of the donated oocytes should be tested and the donor should be prohibited from further donation until the results of such testing are known. If the donor is found to be the carrier for the heritable disease, all women who received oocytes from that donor as well as the clinics performing the procedures should be notified and counseled. A mechanism must exist to maintain records on the donor as a future medical resource for any offspring produced.

K. Legal issues and informed consent
1. All oocyte donors should be advised explicitly of the risks and adverse effects of ovarian stimulation and retrieval, with such counseling documented by informed consent in the patient's permanent medical record.
2. Donors and recipients and their partners, if applicable, should execute documents that define or limit their rights and duties with regard to any offspring.
3. Couples and donors who have legal concerns not addressed in the informed-consent process should be advised to seek legal consultation.
4. Protection of confidentiality: Individuals participating in donor programs should be assured that their confidentiality will be protected insofar as federal and local statutes permit. Medical records detailing the donation should be maintained as stipulated by local requirements.
5. It is recommended that the donor acknowledge in the consent form her responsibility to notify the donor program of any changes in her health or risk-factor status.

GUIDELINES FOR CRYOPRESERVED EMBRYO DONATION

Background

In the current clinical practice of ART, more embryos than can be transferred safely at one time commonly are generated. In the majority of ART practices, these embryos may be cryopreserved for later transfer. Couples who become pregnant and do not desire another pregnancy, or have other reasons for choosing not to use their embryos, may have the option of discarding these embryos or donating them to other individuals or to research. It is the purpose of this document to present guidelines for embryo donation. It should be noted that these guidelines represent minimum standards for screening, testing, and counseling of potential embryo donors and recipients. The federal government has published minimum requirements for embryo donation (6). Some states and other localities may have laws or regulations that pertain to embryo donation that may supersede these guidelines.

I. Guidelines for ART practices that offer embryo donation
A. The practice should be knowledgeable in the storage, thawing, and transfer of frozen embryos.
B. The practice may charge a professional fee to the potential recipients for embryo thawing, the embryo transfer procedure, cycle coordination and documentation, and infectious disease screening and testing of both recipients and donors. However, the selling of embryos per se is ethically unacceptable.
C. It is acceptable for a practice or cryostorage facility to have conservatorship of embryos given up for potential embryo donation by patients whose gametes were used to generate the embryos.
D. Embryos should be quarantined for a minimum of 6 months before the potential donors are screened and tested or retested as noted in section II, with documentation of negative results.
E. Physicians and employees of an infertility practice should be excluded from participating in embryo donation as either donors or recipients within that practice.

II. Embryo donation
Eligibility of donors is determined by the gametes, not the embryos being donated. For embryos derived from gametes obtained from an anonymous donor or donors, the donor or donors must have met all FDA screening and testing requirements and must have been determined eligible for anonymous donation as described above for anonymous sperm and/or oocyte donation. If one or both of the donors is known to the recipient, gametes that were determined to be ineligible still can be used and those embryos are not prohibited from use according to current FDA rules, provided that the tissue is labeled to indicate any associated increased risks and that physicians using samples are aware of the status of the results. Although the FDA does not require informing the recipients of the test results, the ASRM recommends that the recipients be informed and counseled appropriately before transfer of the embryos.
Embryos derived from the gametes of a sexually intimate couple and created for use by that couple are exempt from the requirements for donor screening and testing before creation of the embryos. The following guidelines apply to sexually intimate couples who decide to donate unused embryos that are the product of their own biological gametes:

A. Embryo donors must provide a medical and genetic history.
B. The gamete donors used to create the embryos should be screened for relevant risk factors for HIV, other transmissible infections, and TSE (9).
C. There is no method to ensure completely that infectious agents will not be transmitted, but the following guidelines, combined with an adequate medical history and specific exclusion of individuals at high risk for HIV and other transmissible infections, should dramatically reduce these risks. The practice should determine if the cost of such tests will be borne by the donor couple, by the practice mediating the embryo donation, or by the potential recipients. The following recommended tests should be performed using methods approved by the FDA for use in determining donor eligibility, on both partners, before gamete collection and more than 180 days after cryopreservation of the embryos to be donated.
    1. HIV-1 antibody and NAT.
    2. HIV-2 antibody.
    3. HIV group O antibody. Establishments that do not use an FDA-licensed test for group O antibodies should evaluate donors for risk associated with HIV group O infection (see screening questionnaires for anonymous sperm and oocyte donation).
    4. Hepatitis B surface antigen.
    5. Hepatitis B core antibody (IgG and IgM).
    6. Hepatitis C antibody and NAT.
    7. Serologic test for syphilis.
    8. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* NAT.
    9. Although not required by the FDA, recommended tests also include:
        a. Blood type and Rh factor.
    10. In addition, the male gamete donor should be tested for:
        a. HTLV-1 and HTLV-2.
        b. CMV (IgG and IgM) antibody.
    11. If not already performed, appropriate genetic evaluation and testing should be conducted.
D. Often, screening and testing of the biological source of the gametes used to create the embryos in sexually intimate partners was not done, and the decision to donate embryos occurred subsequent to their creation. If the decision to donate is made more than 180 days after cryopreservation of the embryos, the donors may be rescreened and tested. In this instance, the documentation that accompanies the embryos must include the following label: "Advise recipient that screening and testing of the donors were not performed at the time of cryopreservation of the reproductive cells or tissue but have been performed subsequently."
E. If the donors are not available or refuse to undergo the required screening and testing, FDA guidelines do not preclude the use of their embryos, provided that the documentation that accompanies the embryos includes the following labels: "NOT EVALUATED FOR INFECTIOUS SUBSTANCES," and "WARNING: Advise recipient of communicable disease risks." However, the ASRM recommends careful counseling regarding the risks of transfer of these embryos.
F. Embryos that are shipped to another facility must be accompanied by a summary of records and must be appropriately labeled, in accordance with FDA guidelines. The receiving facility should not accept embryos that are not accompanied by a summary of records or that are not appropriately labeled (10).
G. The embryo donors must sign an informed-consent document indicating their permission to use their embryos for embryo donation. Issues to be addressed in the consent form include:
    1. Relinquishing all rights of the donor(s) to the embryo(s) and any child or children that may result from the transfer of such embryo(s).
    2. Inadvertent loss or damage to the embryo(s).
    3. The right of the practice to refuse transfer to an inappropriate recipient.
    4. The length of time that donated embryos will be maintained in cryostorage, and the alternatives for their disposition thereafter.
    5. Jurisdiction and process for medical/legal procedures and/or dispute resolution.
H. Proper chain-of-custody procedures must be followed and documented for the handling of all test specimens and for donated embryos.
I. Donors should receive no compensation for the embryos.
J. The decision to proceed with embryo donation is complex, and patients may benefit from psychological counseling to aid in the decision. Psychological consultation with a qualified mental health professional is strongly recommended for all couples considering donating embryos. The assessment should include a clinical interview and, where appropriate, psychological testing. The clinician should require psychological consultation for couples in whom there appear to be factors that warrant further evaluation. In circumstances involving known donors, psychological evaluation and counseling is strongly recommended for the donor and partner, if applicable, as well as for the recipient and her partner, if applicable. The potential impact of the relationship between the donor and recipient should be explored. It is important to ascertain whether the donor is well informed about the extent to which information about her may be disclosed and about any plans that may exist relating to future contact.
K. Donors should be advised that additional testing may be necessary prior to releasing embryos for donation.

III. Guidelines for potential recipients
A. The recipient(s) must take full responsibility for the embryo(s) and any child or children that may result from the transfer.
B. The recipient(s) must release the gamete donors from any and all liability from any potential complications of the pregnancies, congenital abnormalities, heritable

diseases, or other complications of the embryo donation. The ART program should also be absolved of liability from potential complications of pregnancy, congenital abnormalities, and heritable diseases.

C. The ASRM recommends that the recipient(s) submit to the same blood tests for infectious disease testing as the donors (V.C.1.a-j under Guidelines for Sperm Donation).

D. Although not required by the FDA, recommended tests also include blood type and Rh factor. If the use of donor embryos creates the potential for Rh incompatibility, couples should be informed about the obstetric significance of this condition.

E. The decision to proceed with embryo donation is complex, and patients may benefit from psychological counseling to aid in this decision. Psychological consultation with a qualified mental health professional is strongly recommended for all individuals receiving donated embryos. The assessment should include a clinical interview and, where appropriate, psychological testing. The physician should require psychological consultation for couples in whom there appear to be factors that warrant further evaluation. In circumstances involving known donors, psychological evaluation and counseling is strongly recommended for the recipient and her partner, if applicable. The potential impact of the relationship between the donor and recipient should be explored. It is important to ascertain whether the recipient is well informed about any plans that may exist relating to future contact.

IV. Record keeping

The FDA requires that records pertaining to each donor (screening and test results) be maintained for at least 10 years. However, in the opinion of the ASRM, a permanent record of each donor's screening and test results should be maintained. To the extent possible, the clinical outcome should be recorded for each donation cycle. A mechanism must exist to maintain such records as a future medical resource for any offspring produced.

V. Protection of confidentiality

Individuals participating in donor programs should be assured that their confidentiality will be protected insofar as federal and local statutes permit. Medical records detailing the donation should be maintained as stipulated by local requirements.

PSYCHOLOGICAL ASSESSMENT OF GAMETE DONORS AND RECIPIENTS

Statement of Purpose

The following recommendations are intended to provide general guidelines for addressing the many complex moral, ethical, and psychosocial issues that confront gamete donors, recipients, and offspring.

I. Donors

A. The decision to proceed with gamete donation is complex, and individuals may benefit from psychological counseling to aid in the decision. Psychological consultation with a qualified mental health professional is strongly recommended for all individuals considering gamete donation. The assessment should include a clinical interview and, where appropriate, psychological testing. The physician should require psychological consultation for donors in whom there appear to be factors that warrant further evaluation.

1. If indicated, psychological testing should document and validate in a standardized objective manner the information gathered from the clinical interview and should include an objective personality test and other self-report measures to assess potential instability or psychopathology.

B. A psychosocial history should include:

1. Family history.
2. Educational background.
3. Assessment of stability.
4. Motivation to donate.
5. Current life stressors and coping skills.
6. Difficult or traumatic reproductive history.
7. Interpersonal relationships.
8. Sexual history.
9. Travel history.
10. History of major psychiatric and personality disorders.
11. Substance abuse in donor or first-degree relatives.
12. Legal history.
13. History of abuse or neglect.

C. The psychological assessment should ensure that the donor has been informed about all relevant aspects of the medical treatment. Donors should be counseled about the number and type of infectious disease tests that will be performed and informed about how that information will be used and shared with others.

D. The psychological assessment also should address the potential psychological risks and should evaluate for evidence of coercion (financial or emotional). It also is important to ascertain whether the donor is well informed about the extent to which information about him/her might be disclosed and about any plans that may exist relating to future contact. The donor must be aware of all aspects of potential embryo management and disposition applicable to that practice. Donors should be informed about how the information will be used, stored, and secured.

E. Relative exclusion criteria for a gamete donor include:

1. Presence of significant psychopathology.
2. Positive family history of heritable psychiatric disorders.
3. Substance abuse.
4. Two or more first-degree relatives with substance abuse.
5. Current use of psychoactive medications.
6. History of sexual or physical abuse with no professional treatment.
7. Excessive stress.
8. Marital instability.
9. Impaired cognitive functioning.
10. Mental incompetence.

11. High-risk sexual practices.

F. Candidates who are excluded from the donor practice should be counseled regarding the reasons for their exclusion and, if appropriate, offered referral.

G. In cases involving known donors, related issues such as the potential impact of the relationship between the donor and recipient should be explored. The impact on treatment failure also should be addressed.

II. Recipients

A. The decision to proceed with gamete donation is complex, and patients may benefit from psychological counseling to aid in the decision. Psychological consultation with a qualified mental health professional is strongly recommended for all patients considering gamete donation. The assessment should include a clinical interview and, where appropriate, psychological testing. The physician should require psychological consultation for patients in whom there appear to be factors that warrant further evaluation.

B. The recipient should be counseled about his/her subsequent feelings concerning the medical conditions that necessitated the use of donor gametes.

C. Counseling should address the impact of successful treatment: feelings during pregnancy, positive and negative aspects of disclosure and nondisclosure with offspring, potential impact of multiple pregnancy, transition to parenthood, parenting at an older age (if applicable), and nonbiological parenting issues.

D. The impact of treatment failure also should be addressed: coping with treatment termination, the grieving process, and developing alternatives for the future.

E. In cases involving known donors, related issues, such as the potential impact of the relationship between donor and recipient, should be explored.

F. The recipients should be informed about the screening and testing required of the donor. The couple should be made aware that a donor may be deemed unsuitable for donation and that the practice may refuse to use these gametes for treatment. If the recipient couple elects to use a donor who is deemed unsuitable, then additional counseling must involve risk management and an agreement that the recipient couple understands and assumes the risk. Couples should be informed that the records related to the screening and testing of the donor will be stored. The storage of this information is relevant to the recipients because it relates to other information-sharing decisions they may make.

PSYCHOLOGICAL GUIDELINES FOR EMBRYO DONATION

Statement of Purpose

The following recommendations are intended to provide general guidelines for addressing the many complex moral, ethical, and psychosocial issues that confront embryo donors, recipients, and offspring.

I. Donors

A. All potential donor couples should be informed about all aspects of their medical treatments and the relevant psychological and ethical issues inherent in donating embryos.

B. There should be a discussion of embryo disposition options before cryopreservation. After couples have concluded their own reproductive attempts, embryo disposition options should be re-evaluated.

C. The decision to proceed with embryo donation is complex, and patients may benefit from psychological counseling to aid in the decision. Psychological consultation with a qualified mental health professional is strongly recommended for all patients considering donating embryo(s). The assessment should include a clinical interview and, where appropriate, psychological testing. The clinician should require psychological consultation for patients in whom there appear to be factors that warrant further evaluation. In circumstances involving known donors, psychological evaluation and counseling is strongly recommended for the donors. The potential impact of the relationship between the donor and recipient should be explored. It is important to ascertain whether the donor is informed about any plans that may exist relating to future contact. The assessment should occur after couples have concluded their own reproductive attempts and have clearly indicated their desire to donate embryos.

D. The clinical interview should include a psychosocial history of both partners, which addresses:

1. Family history.
2. Educational background.
3. Assessment of stability.
4. Motivation to donate.
5. Current life stressors and coping skills.
6. Difficult or traumatic reproductive history.
7. Interpersonal relationships.
8. Sexual history.
9. History of major psychiatric and personality disorders.
10. Substance abuse in donor or first-degree relatives.
11. Legal history.
12. History of abuse or neglect.
13. Emotional attachment to embryo.

E. If indicated, psychological testing is recommended to document and validate in a standardized objective manner the information gathered from the clinical interview and should include an objective personality test and other self-report measures to assess potential instability or psychopathology.

F. Relative exclusion criteria for an embryo donor include:

1. Presence of significant psychopathology.
2. Positive family history of heritable psychiatric disorders.
3. Substance abuse.
4. Two or more first-degree relatives with substance abuse.
5. Current use of psychoactive medications.

6. History of sexual or physical abuse with no professional treatment.
7. Excessive stress.
8. Marital instability.
9. Impaired cognitive functioning.
10. Mental incompetence.
11. High-risk sexual practices.

G. A minimum 3-month waiting period with appropriate follow-up assessment is recommended between the time a couple signs the consent form to donate embryos and the actual donation to a recipient couple.

H. Physicians and employees of an infertility practice may not participate in embryo donation (as donors or recipients) within that practice.

I. Donors should not be compensated for their donated embryos.

J. Donors should be at least 21 years of age.

K. All potential donor couples should be advised at the time of the IVF procedure that additional screening and testing may be required if they elect to donate their embryos. The couple should be counseled about their possible ineligibility to donate embryos.

II. Recipients and their partners

A. Recipients of donor embryos and their partners should receive counseling about the potential psychosocial implications.

B. The decision to proceed with embryo donation is complex, and patients may benefit from psychological counseling to aid in the decision. Psychological consultation with a qualified mental health professional is strongly recommended for all patients considering embryo donation. The assessment should include a clinical interview and, where appropriate, psychological testing. The physician should require psychological consultation for patients in whom there appear to be factors that warrant further evaluation.

C. The recipient and her partner should be counseled about their subsequent feelings concerning the medical conditions that made necessary the use of donor embryos.

D. The impact of treatment failure also should be addressed, including coping with treatment termination, the grieving process, and developing alternatives for the future.

E. Relative issues, such as the impact of the relationship between known donors, recipients, and offspring, should be explored.

F. This assessment should attempt to exclude significant psychiatric illness and current substance abuse and to evaluate their ability to cope with the stress of ART.

G. Recipients of donor embryos should be advised of screening and testing requirements and be prepared either to not use or to assume the risks related to the use of donor embryos.

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APPENDIX A

MINIMUM GENETIC TESTING FOR GAMETE AND EMBRYO DONORS (2–4)

The American Society for Reproductive Medicine; Birmingham, Alabama

I. The donor
   A. Should not have any major Mendelian disorder. Mendelian disorders fall into the following categories:
      a. Autosomal dominant or X-linked disorders. Providers should be aware that some autosomal dominant or X-linked disorders can have variable expressivity (meaning that mutation carriers may not have noticeable symptoms) or have an age of onset that extends beyond the age of the donor (one example is Huntington disease).
      b. Autosomal recessive disorders. Donors who are heterozygous need not necessarily be excluded if the reproductive partner has had appropriate carrier screening. The recipient and reproductive partner (as appropriate) should be counseled about the accuracy of the carrier screening test and the residual risk to be a carrier following a negative test. Counseling regarding residual risk is complex and may be best provided by a genetic counselor.
   B. Should not have (or have had) any major malformation of complex cause (multifactorial/polygenic), such as spina bifida or cardiac malformation. A major malformation is defined as one that carries serious functional or cosmetic handicap. However, the definition of "major" is a matter of judgment.
   C. Should not have any significant familial disease with a major genetic component.
      Note: Assessment of hereditary risk factors by family history review is performed best by a genetic counselor. However, this screening may be performed by any professional trained in medical genetics at the discretion of the individual program.
   D. Should not have a known karyotypic abnormality that may result in chromosomally unbalanced gametes. In the general population, the chance of having a chromosomal rearrangement that could be transmitted in unbalanced form to offspring is small, provided the family history is negative for risk factors. Therefore, routine karyotyping of all donors is optional.
   E. Should undergo general population and ethnicity (ancestry)-based genetic screening. Donors should give informed consent prior to carrier screening. Informed consent should include discussion of the natural history of the condition being screened, carrier frequency in the respective ethnic group, detection rate of the test, residual risk to be a carrier when testing negative, and options for persons testing positive. If a prospective donor is identified as a carrier, genetic counseling for both the donor and recipient is recommended (6).
      The recommended list of tests may change as tests for other disorders are developed. Guidelines regarding ethnicity and population-based genetic screening are published by the American Congress of Obstetricians and Gynecologists (http://www.acog.org) and the American College of Medical Genetics (http://www.acmg.net/). All gamete donors should be evaluated by the current tests recommended at the time of the donation.
      Note: It is not appropriate to screen gamete donors for adult onset conditions (such as cancer predisposition, Huntington disease, etc.) without full consent of the gamete donor, including formal genetic counseling (7).
   F. Should be generally healthy and young. Advanced maternal age is associated with an increased risk for aneuploid offspring. Advanced paternal age is associated with a moderately increased risk for new mutations in offspring, and an emerging body of evidence suggests an increased risk for complex disorders, including some congenital anomalies, schizophrenia, autism spectrum disorders, and specific forms of cancer.

II. The donor's first-degree relatives (parents, siblings, and offspring) should be free of:
   A. Mendelian disorders as described in Section I.A.
   B. Major malformations as described in Section I.B.
   C. Significant familial disease with a major genetic component.
   D. A chromosomal abnormality, unless the donor has a normal karyotype.
   E. Mental retardation of undocumented etiology.

If family history reveals a disorder for which definitive testing is available, then it is appropriate to refer the prospective donor for genetic counseling for that specific disorder. Testing without a formal genetic consultation would be inappropriate. Genetic test results may determine the appropriateness of using that donor.