RESOLVED, That the American Bar Association adopts the ABA Model Act Governing Assisted Reproduction [2019] dated January 28, 2019 (“Model Act [2019]”) to replace the 2008 ABA Model Act Governing Assisted Reproductive Technology; and

FURTHER RESOLVED, That the American Bar Association approves the Model Act [2019] as an appropriate Act for those states desiring to adopt the specific substantive law contained in the Act.
ARTICLE 1. GENERAL PROVISIONS

SECTION 101. SHORT TITLE
SECTION 102. DEFINITIONS

ARTICLE 2. INFORMED CONSENT

SECTION 201. INFORMED CONSENT STANDARDS
SECTION 202. RECORD AUTHORIZATION REQUIRED
SECTION 203. DISCLOSURES
SECTION 204. DONOR LIMITATIONS
SECTION 205. COLLECTION OF GAMETES OR EMBRYOS FROM CRYOPRESERVED TISSUE OR FROM DECEASED OR INCOMPETENT INDIVIDUALS
SECTION 206. LOSS OF EMBRYOS OR GAMETES DUE TO NATURAL DISASTER, ACT OF GOD, TERRORISM OR WAR

ARTICLE 3. MENTAL HEALTH EVALUATION AND ADDITIONAL COUNSELING

SECTION 301. MENTAL HEALTH EVALUATION
SECTION 302. ADDITIONAL COUNSELING REQUIREMENTS

ARTICLE 4. PRIVACY AND CONFIDENTIALITY

SECTION 401. INDIVIDUALLY IDENTIFIABLE MEDICAL INFORMATION
SECTION 402. INFORMATION ABOUT DONORS

ARTICLE 5. EMBRYO TRANSFER AND DISPOSITION OF GAMETES AND EMBRYOS

SECTION 501. DISPOSITION OF GAMETES AND EMBRYOS
SECTION 502. DONATION OF UNUSED GAMETES AND EMBRYOS
SECTION 503. SCREENING OF GAMETE AND EMBRYO DONORS
SECTION 504. ABANDONMENT OF GAMETES AND EMBRYOS AND DISPOSITION OF ABANDONED GAMETES AND EMBRYOS
SECTION 505. TRANSPORTATION OF GAMETES AND EMBRYOS

ARTICLE 6. CHILD OF ASSISTED REPRODUCTION

SECTION 601. SCOPE OF ARTICLE
SECTION 602. PARENTAL STATUS OF DONOR
SECTION 603. PARENTAGE OF CHILD OF ASSISTED REPRODUCTION
SECTION 604. CONSENT TO ASSISTED REPRODUCTION
SECTION 605. LIMITATION LEGAL SPOUSE’S DISPUTE OF PARENTAGE
SECTION 606. EFFECT OF DISSOLUTION OF MARRIAGE OR WITHDRAWAL OF CONSENT
SECTION 607. PARENTAL STATUS OF DECEASED INDIVIDUAL

ARTICLE 7. SURROGACY

SECTION 701. SURROGACY AGREEMENTS AUTHORIZED
SECTION 702. ELIGIBILITY
SECTION 703. REQUIREMENTS FOR A SURROGACY AGREEMENT
SECTION 704. TERMINATION OF SURROGACY AGREEMENT PRIOR TO PREGNANCY
SECTION 705. ESTABLISHMENT OF PARENT CHILD RELATIONSHIP - GESTATIONAL SURROGACY
SECTION 706. ESTABLISHMENT OF PARENT CHILD RELATIONSHIP – GENETIC SURROGACY
SECTION 707. DUTY TO SUPPORT
SECTION 708. EFFECT OF SURROGATE’S SUBSEQUENT MARRIAGE
SECTION 709. IRREVOCABILITY
SECTION 710. NONCOMPLIANCE
SECTION 711. EFFECT OF NONCOMPLIANCE
SECTION 712. IMMUNITIES
SECTION 713. DAMAGES
SECTION 714. INSPECTION OF RECORDS
SECTION 715. EXCLUSIVE, CONTINUING JURISDICTION

ARTICLE 8. PAYMENT TO DONORS AND GESTATIONAL AND GENETIC SURROGATES

SECTION 801. REIMBURSEMENT
SECTION 802. COMPENSATION

ARTICLE 9. HEALTH INSURANCE

SECTION 901. INFERTILITY AND EXPERIMENTAL PROCEDURES
SECTION 902. REQUIRED NOTICE
SECTION 903. QUALIFICATION OF PROVIDERS

ARTICLE 10. QUALITY ASSURANCE

SECTION 1001. QUALIFICATION OF PROVIDERS
SECTION 1002. COLLABORATIVE REPRODUCTION REGISTRIES
SECTION 1003. HEALTH INFORMATION MANAGEMENT
SECTION 1004. PATIENT SAFETY
ARTICLE 11. ENFORCEMENT

SECTION 1101. DAMAGES

ARTICLE 12. MISCELLANEOUS PROVISIONS

SECTION 1201. LIMITATION OF MEDICAL PROFESSIONAL LIABILITY

SECTION 1202. SEVERABILITY
ARTICLE 1. GENERAL PROVISIONS

SECTION 101. SHORT TITLE

This Act is entitled the Model Act Governing Assisted Reproduction [2019].

SECTION 102. DEFINITIONS

1. “ART Storage Facility” means a licensed facility that stores reproductive, biological, or genetic material used in Assisted Reproductive Technology, and is in compliance with the Fertility Clinic and Certification and Success Rate Act of 1992 (FCSRCA, or Public Law 102-493).

2. “Assisted Reproduction” means a method of causing pregnancy through means other than by sexual intercourse. In the foregoing context, the term includes, but is not limited to:
   (a) Intrauterine or intracervical insemination;
   (b) Donation of eggs or sperm;
   (c) Donation of Embryos;
   (d) In vitro fertilization and Embryo Transfer; and
   (e) Intracytoplasmic sperm injection.

3. “Assisted Reproductive Technology” (“ART” as used in this Act) means any medical or scientific procedures or treatment provided by a medical Provider, with the intent of having a Child.


5. “Child” means an individual born pursuant to Assisted Reproduction whose parentage may be determined under this Act or other law.

6. “Collaborative Reproduction” means any Assisted Reproduction in which an individual other than an Intended Parent provides genetic material or any Assisted Reproduction involving a Gestational or Genetic Surrogate.

7. “Compensation” means payment of any valuable consideration for time, effort, pain and/or risk.

8. “Consultation” means a meeting with a licensed mental health professional for the purpose of counseling and educating the Participant in accordance with ASRM guidelines about the effects and potential consequences of their participation in any ART procedure.

9. “Court” means the appropriate court with competent jurisdiction as determined by the State.
10. “Donor” means an individual, including an Embryo Donor or a Genetic Surrogate, who provides gametes for Assisted Reproduction. The term does not include: (a) an Intended Parent who provides gametes to be used for Assisted Reproduction; (b) a woman who gives birth to a Child by means of Assisted Reproduction except as otherwise provided in Article 6; or (c) a Parent under Article 6 or an Intended Parent under Article 7.

11. “Embryo” means a fertilized egg that has the potential to develop into a fetus if transferred into a uterus.

12. “Embryo Donor” means an individual who transfers ownership of an Embryo to another and intends to have no parental rights or obligations to the resulting Child.

13. “Embryo Transfer” (also referred to herein as “Transfer”) means the placement of an Embryo into a uterus.

14. “Escrow Account” means an independent, insured, bonded escrow depository maintained by a licensed, independent, bonded escrow company; or an insured and bonded trust account maintained by an attorney.

   (a) For purposes of this section, a non-attorney ART Agency may not have a financial interest in any escrow company holding client funds. A non-attorney ART Agency and any of its officers, managers, owners of more than 5% ownership interest, directors or employees shall not be an agent of any escrow company holding client funds; and

   (b) Client funds may only be disbursed by the attorney or Escrow Agent as set forth in the assisted reproduction agreement and the fund management agreement between the Intended Parent(s) and the Escrow Account holder.

15. “Escrow Agent” means the trustee for an Escrow Account.

16. “Evaluation” means a Consultation with and, where required by this Act, an assessment in accordance with ASRM guidelines as to whether a Participant is cleared to proceed with participation in any ART procedure.

17. “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 are Gametes. A Gamete may consist of nuclear DNA from one human being combined with the cytoplasm, including cytoplasmic DNA, of another human being.

18. “Gamete Provider” means an individual who provides sperm or eggs for use in Assisted Reproduction.
19. “Genetic Surrogate” means an adult, not an Intended Parent, who enters into a Surrogacy Agreement to bear a Child and who is a Gamete Provider for the Child.

20. “Genetic Surrogacy Agreement” is a written contract between Intended Parent(s) and a Genetic Surrogate.

21. “Genetic Surrogacy Arrangement” means the process by which a Genetic Surrogate intends to carry and give birth to a Child.

22. “Gestational Surrogate” means an adult, not an Intended Parent, who enters into a Surrogacy Agreement to bear a Child and who is not a Gamete Provider for the Child.

23. “Gestational Surrogacy Agreement” is a written contract between Intended Parent(s) and a Gestational Surrogate.

24. “Gestational Surrogacy Arrangement” means the process by which a Gestational Surrogate intends to carry and give birth to a Child.

25. “Independent Legal Representation” (also referred to herein as “Independent Legal Counsel”) means representation of the Participants by separate legal counsel as required by the applicable rules of professional responsibility.

26. “Infertility” means the definition set forth by ASRM.

27. “Intended Parent” means an individual who intends to be legally bound as a Parent of the Child.

28. “Legal Spouse” means an individual married to another.

29. “Medical Evaluation” means a Consultation with and an evaluation by a physician meeting the requirements of Section 903.

30. “Medical Information” means any protected individually identifiable health information obtained by a health care provider in the course of Medical Evaluation, Consultation, diagnosis, or treatment.

31. “Mental Health Counseling” means additional Consultation(s) after an initial Consultation for the purpose of advising and supporting the Participant throughout the implementation of any ART procedure.

32. “Mental Health Evaluation” means a Consultation with and an evaluation by a mental health professional meeting the requirements of Section 301.

33. “Parent” means an individual who has established a Parent-Child Relationship under this Act or other applicable law.
34. “Parent-Child Relationship” means the legal relationship between the Child and a Parent of the Child.

35. “Participant” means an Intended Parent, Donor, Gestational or Genetic Surrogate and their Legal Spouse, if applicable, who is involved in Collaborative Reproduction under this Act.

36. “Patient” means an individual participating in Assisted Reproduction under the direction of a Provider.

37. “Physician” means an individual licensed to practice medicine.

38. “Provider” means an individual, including all medical, psychological, or counseling professionals: (a) licensed to administer health care; (b) who is qualified under this Act to provide Assisted Reproduction services; and (c) has a Provider-Patient relationship with a Participant. Any professional corporation or corporation licensed by the State to provide health care, of which a Provider is an owner or employee, is also a Provider.

39. “Record” means information inscribed in a tangible medium or stored in an electronic or other medium that is retrievable in perceivable form.

40. “Retrieval” means the procurement of eggs or sperm from a Gamete Provider.

41. “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.

42. “Surrogacy Agreement” is a written contract between Intended Parent(s) and a Gestational or Genetic Surrogate.

43. “Surrogacy Arrangement” means the process by which a Gestational or Genetic Surrogate intends to carry and give birth to a Child.

44. “Transfer” means a procedure for Assisted Reproduction by which an Embryo or sperm is placed into the body of the individual who will give birth to a Child.

ARTICLE 2. INFORMED CONSENT

The requirements of Article 2 apply only to medical facilities providing ART to Participants.

SECTION 201. INFORMED CONSENT STANDARDS

1. Informed consent must be provided by all Participants to the ART Provider prior to the commencement of any medical or scientific procedures or treatment.
2. Informed consent requires that all of the following be provided to all Participants orally and in a Record that meets the requirements of Section 202:

(a) A statement that the Patient retains the right to withhold or withdraw consent at any time prior to Transfer of Gametes or Embryo Transfer without affecting the right to receive and/or make decisions about future care or treatment, or risking the loss or withdrawal of any program benefits to which the Patient would otherwise be entitled.

(b) A statement that the ART Provider retains the right to withdraw for reasonable justification and with reasonable notice.

(c) A statement that the Donor’s right to withhold or withdraw consent to fertilization terminates upon Retrieval of his or her Gametes, subject only to the terms of any prior agreement in a Record pursuant to Article 5.

(d) A statement of the known, potential medical and procedural risks and benefits of ART. Such description shall include the inherent risk of Embryo loss due to aneuploidy, thawing, and failure of implantation; the risks associated with the use of hormones and other drugs that may be used; the procedural risks associated with egg Retrieval and/or other ART procedures; the incidence of, and risks regarding, multiple pregnancies and selective reduction; and the incidence and risk of birth defects associated with IVF.

(e) A statement of acknowledgement that alternative therapies and options have been discussed in detail.

(f) A statement that the Patient shall be informed that there may be foreseen, or unforeseen legal consequences and that Independent Legal Representation is advisable and may be required by this Act or by State law.

(g) A statement describing all existing confidentiality protections.

(h) A statement of guarantee that a Patient, whether a Donor, Intended Parent, Gestational Surrogate or Genetic Surrogate (a Participant), has access to all of his/her Medical Information to the extent allowed by applicable law and not otherwise waived by the Participant. The Patient may have to pay a fee for copies of the Record.

(i) A statement that the Intended Parent has a right to access a summary of medical and psychological information about Donors and Gestational or Genetic Surrogates as described in this Act.

(j) A statement that the release of any Participant-identifiable information, including images, shall not occur without the consent of the Participant in a Record.
(k) A statement that the Intended Parent(s) or an Embryo Donor, not the ART Provider or ART Storage Facility, has the right to possession and control of their Embryos, subject to any prior agreement in a Record or as provided in Section 504.

(l) A statement of the need for Intended Parents to agree in advance who shall acquire the right to possession and control of the Embryos or Gametes in the event of marriage dissolution or separation of the Intended Parents, death of one or both of them, or subsequent disagreement over disposition in compliance with the provisions of Section 501 of this Act.

(m) The policy of the provider regarding the number of Embryos Transferred and any limitation on the number of Embryos Transferred, as well as the existence of national guidelines as published by the ASRM.

(n) A statement of the need for Participants to decide whether the Embryos or Gametes can be used for purposes other than Assisted Reproduction.

(o) Signed in presence of member of staff of the Provider or notary.

SECTION 202.  RECORD AUTHORIZATION REQUIRED

1. The Provider must document informed consent in a Record for each Participant that must:

   (a) Be in plain language;

   (b) Be dated and signed by the Provider and by the Participant in the presence of a member of the staff of the provider or before a notary;

   (c) State that disclosures have been made pursuant to this Act;

   (d) Specify the length of time the consent remains valid; and

   (e) Advise the party signing the informed consent document of the right to receive a copy of the Record.

2. The Record(s) must be executed in accordance with this Act before informed consent is valid or the commencement of any ART.

3. The Record required in paragraph 1 of this Section shall become part of the medical record.

4. Prior to the start of any medications, the Record must reflect whether the Participants have entered into a legal agreement.
SECTION 203. DISCLOSURES

1. Disposition of cryopreserved Gametes or Embryos: Prior to each Retrieval, a Provider must disclose to all Intended Parents and Donors, whose identity is known to the Provider, the following possible dispositions of Embryos:

(a) Storage, including length of time, costs, and location;

(b) Embryo Transfer;

(c) Donation:
   (i) To a known individual for Embryo Transfer;
   (ii) To an anonymous individual for Embryo Transfer, either directly or through the provider, or through a third party Embryo donation program;
   (iii) For scientific or clinical research, including the institution conducting the research and the intended nature of the research, if known, subject to any agreement in a Record as provided in Section 502; or

(d) Destruction.

2. Right to transport. A Provider is not required to offer all possible dispositions, but the provider must inform the Patient that other providers may offer other options and that the Patient has the right to transport Embryos to other providers.

3. Embryo Transfer disclosure. Before each Embryo Transfer cycle, the Provider must provide each Intended Parent with the following information in a Record, where applicable:

(a) Method used to achieve fertilization and the results of semen analysis, including, but not limited to, motility, count, and morphology;

(b) Number of eggs retrieved;

(c) For the Retrieval and Transfer of fresh Embryos:
   (i) Number formed;
   (ii) Number viable for Embryo Transfer;
   (iii) Number to be Transferred;
   (iv) Number to be cryopreserved;
(v) Quality of each Embryo Transferred; and
(vi) Quality of each Embryo cryopreserved;

(d) For the Transfer of cryopreserved Embryos:

(i) Number of Embryos thawed;
(ii) Number of Embryos viable for Embryo Transfer after thawing; and
(iii) Quality of Embryos Transferred;
(iv) Remaining viability of thawed but unused Embryos, if any.

(e) A statement that failure to adhere to drug administration schedules may affect
the outcome of the treatment.

4. Disclosure to Donors. If additional information is learned through Medical Evaluation or
Mental Health Evaluation prior to or upon Retrieval of Gametes that is relevant to the
Donor’s health that information must be made available to the Donor if the Donor has
made such a request. The Provider must disclose to a Donor that such information can
be made available upon request.

5. Disclosure regarding health. Individuals from whom eggs are retrieved must be
informed prior to the Retrieval or commencement of medications of the health risks and
adverse effects of ovarian stimulation and retrieval. Women undergoing Transfer must
be informed of the health risks of that process. Health risk disclosures must include,
where relevant, the following information regarding the fertility drugs to be used:

(a) Known potential present and future side effects;
(b) Alternative drug therapies and natural cycling;
(c) Process of drug administration; and
(d) Whether the drug is approved by the Food and Drug Administration (FDA).

6. Disclosure regarding multiple births/Retrievals. Where relevant, a Provider must
disclose in a Record, to Participants other than Donors, prior to Retrieval, the known risks
of multiple births to the Participant and to the fetuses, including the positive and negative
factors involved in selective reduction; and the known potential birth defects related to
IVF. A Provider must disclose prior to Retrieval to individuals undergoing egg retrieval
the known potential present and future risks of multiple courses of ovarian stimulation
drugs. A Provider must disclose prior to Embryo Transfer to a Gestational Surrogate or
Genetic Surrogate the number of embryos to be transferred.
7. Disclosure regarding Embryo research. A Provider shall not accept from a Participant an Embryo designated for research under Section 502, and the Provider must disclose the existence of any financial or professional relationship with any entity accepting the Embryo for research.

SECTION 204. DONOR LIMITATIONS

In accordance with the requirements set forth elsewhere in this Act:

1. A Donor of Gametes or Embryos may condition donation on a reasonable assurance of anonymity so long as non-identifying health information is provided.

2. A Donor who has given permission for release of identifying health or other information may not revoke such permission after transfer of ownership of the donated Gametes or Embryos.

3. A Donor of Gametes or Embryos may condition donation on other reasonable use or disposition restrictions as set forth in a Record prior to donation.

SECTION 205. COLLECTION OF GAMETES FROM CRYOPRESERVED TISSUE OR GAMETES FROM DECEASED OR INCOMPETENT INDIVIDUALS

1. Gametes shall not be collected from deceased or incompetent individuals or from cryopreserved tissues unless consent in a Record was executed prior to death or incompetency by the individual from whom the Gametes are to be collected, or the individual’s authorized fiduciary who has express authorization from the principal to so consent, does consent.

2. In the event of an emergency where the required consent is alleged but unavailable and where, in the opinion of the treating Physician, loss of viability would occur as a result of delay, and where there is a genuine question as to the existence of consent in a Record, an exception is permissible.

3. If Gametes are collected pursuant to paragraph 2 of this Section, Transfer of Gametes or of an Embryo formed from such a Gamete is expressly prohibited unless approved by a Court. Absence of a Record as described in paragraph 1 of this Section shall constitute a presumption of non-consent.

Legislative Note: States should customize this article to comport with the State’s criminal code.

SECTION 206. LOSS OF EMBRYOS OR GAMETES DUE TO NATURAL DISASTER, ACT OF GOD, TERRORISM, OR WAR
An ART Storage Facility for Embryos or Gametes is not liable for destruction or loss of Embryos due to natural disaster, act of God, terrorism or war.

**ARTICLE 3. MENTAL HEALTH EVALUATION AND ADDITIONAL COUNSELING**

The requirements of Article 3 apply only to medical facilities providing ART to Participants.

**SECTION 301. MENTAL HEALTH EVALUATION**

1. Intended Parents must receive a Consultation prior to undergoing any Collaborative Reproduction ART procedure.

2. All other Participants known to the ART Provider, other than Intended Parents, must undergo a Mental Health Evaluation with a Mental Health Professional in accordance with the most recently published Professional Guidelines of ASRM prior to Collaborative Reproduction ART procedure. The results of this Evaluation shall only be used to determine suitability to participate in Collaborative Reproduction.

3. During a Consultation or Mental Health Evaluation described above, the Provider must inform the Participant(s) of additional counseling options. The Participant’s acceptance of additional counseling is voluntary.

4. For purposes of this Article, Mental Health Professional is an individual who:
   (a) Holds a master’s or doctoral degree in the field of psychiatry, psychology, counseling, social work, psychiatric nursing, marriage and family therapy, or State equivalent; and
   (b) Is licensed, certified, or registered to practice in the mental health field; and
   (c) Has received training in reproductive physiology; the testing, diagnosis, and treatment of Infertility; and the psychological issues in Infertility and Collaborative Reproduction. If there are questions about inherited or genetic disorders, the Mental Health Professional must refer the Participant to a qualified professional for Consultation.

**SECTION 302. ADDITIONAL COUNSELING REQUIREMENTS**

1. An ART procedure using Collaborative Reproduction shall not be initiated or performed until:
   (a) All Participants made known to the ART Provider have been offered Mental Health Counseling following the initial Mental Health Evaluation or Consultation as provided for in Section 301; and
(b) The Mental Health Professional(s) have prepared and delivered to the medical Provider(s) a statement in a Record that he or she has met with the Participant(s) and that they have undergone the requisite Mental Health Evaluation and/or Consultation;

2. Opportunity to receive counseling. It shall be conclusively presumed that a Participant has been offered an opportunity to receive additional counseling from a Mental Health Professional pursuant to Section 301 if that individual signs a statement containing the following language:

"I understand that counseling is recommended for all participants in collaborative reproduction and that counseling is a separate process from any consultation that [Provider] has required me to complete. [Provider] has given me the opportunity to meet with and receive counseling from a mental health professional with specialized knowledge of the social and psychological impact of assisted and collaborative reproduction on participants. I understand that I may choose any such mental health professional, and that I am not required to choose one recommended by this treatment facility."

3. Assessment available to Intended Parents. A Mental Health Professional’s recommendation regarding the assessment of a Gamete Donor or Surrogate Participant for Collaborative Reproduction shall be transmitted to an Intended Parent only if:

(a) Intended Parent has requested such recommendation;

(b) Intended Parent’s request is prior to Transfer of Gametes or Embryos;

(c) Intended Parent’s request is prior to execution of any Collaborative Reproduction agreement; and

(d) The affected Participant’s Informed Consent was obtained pursuant to Article 201.

(e) Any such transmission as well as the retention of the information transmitted or the documents or other materials upon which the assessment was based, shall otherwise be controlled by applicable state or Federal law.

ARTICLE 4. PRIVACY AND CONFIDENTIALITY

The requirements of Article 4 apply only to medical facilities providing ART to Participants.

SECTION 401. INDIVIDUALLY IDENTIFIABLE MEDICAL INFORMATION

All individually identifiable information obtained or created in the course of ART treatment is Medical Information and subject to medical record confidentiality requirements.
SECTION 402. INFORMATION ABOUT DONORS

1. DEFINITIONS.

(a) “Identifying information” means: the full name of a Donor; the date of birth of the Donor; and the permanent and, if different, current address of the Donor at the time of the donation.

(b) “Medical history” means information regarding any: present illness of a Donor; past illness of the Donor; and social, genetic, and family history pertaining to the health of the donor.

2. COLLECTION OF INFORMATION.

For Gametes collected after the effective date of this Act, a Gamete bank or Provider licensed in this State shall collect from a Donor the Donor’s identifying information and medical history at the time of the donation. If the Gametes of a Donor are sent to another Gamete bank or Provider, a sending Gamete bank or Provider also shall forward any identifying information and medical history of the Donor, including the Donor’s signed declaration under Section 402 (3) regarding identity disclosure, to a receiving Gamete bank or Provider. A receiving Gamete bank or Provider licensed in this State must collect and retain the information about the Donor and the sending Gamete bank or Provider.

3. DECLARATION REGARDING IDENTITY DISCLOSURE.

(a) A Gamete bank or Provider licensed in this State that collects Gametes from a Donor shall:

(i) provide the Donor with information in a Record about the Donor’s choice regarding identity disclosure; and

(ii) obtain a declaration from the Donor regarding identity disclosure.

(b) The Gamete bank or Provider shall give the Donor the choice to sign a declaration, attested by a notarial officer or witnessed by at least one individual, that either:

(i) states that the Donor agrees to disclose the Donor’s identity to a Child conceived by assisted reproduction with the Donor’s Gametes on request once the Child becomes 18 years of age; or

(ii) states that the Donor presently does not agree to disclose the Donor’s identity to the Child.
(c) The Gamete bank or Provider shall permit a Donor who has signed a declaration under paragraph (b)(ii) of this Section to withdraw the declaration by signing a declaration under paragraph (b)(i) of this Section at any time.

4. DISCLOSURE OF IDENTIFYING INFORMATION AND MEDICAL HISTORY.

(a) On request of a Child conceived by Assisted Reproduction who is at least 18 years of age, a Gamete bank or Provider licensed in this State which collected, stored, or released for use the Gametes used in the Assisted Reproduction shall make a good-faith effort to provide the Child with identifying information of the Donor who provided the Gametes, unless the Donor signed and did not withdraw a declaration under paragraph 3(b)(ii) of this Section. If the Donor signed and did not withdraw a declaration under paragraph 3(b)(ii) of this Section, the Gamete bank or Provider must make a good-faith effort to notify the Donor, who may elect disclose the Donor's identity declaration under paragraph 3(b)(i) of this Section.

(b) Regardless of whether a Donor signed a declaration under paragraph 3 of this Section, on request by a Child conceived by Assisted Reproduction who is at least 18 years of age, or, if the Child is a minor, by a Parent or guardian of the Child, the Gamete bank or Provider shall make a good faith effort to provide the Child or, if the Child is a minor, the Parent or guardian of the Child, access to non-identifying medical history of the Donor.

5. RECORDKEEPING. A Gamete bank or Provider licensed in this State, which collects, stores, or releases Gametes for use in Assisted Reproduction, shall collect and maintain identifying information and medical history about each Donor. The Gamete bank or Provider shall collect and maintain records of Gamete screening and testing and comply with reporting requirements, in accordance with federal law and applicable law of this State other than this Act.

ARTICLE 5. EMBRYO TRANSFER AND DISPOSITION OF GAMETES OR EMBRYOS

The requirements of Article 5 apply only to medical facilities providing ART to Participants.

SECTION 501. DISPOSITION OF GAMETES AND EMBRYOS

1. Intended Parent(s) shall enter into a written agreement prior to Embryo formation through in vitro fertilization detailing:

   (a) Intended use of Embryos;

   (b) Disposition of cryopreserved Embryos in the event of:

      (i) Dissolution of Intended Parents' relationship (or divorce of Intended Parents, if married); and
(ii) Incapacity or death of one or both Intended Parents.

2. Such agreements may be amended in a Record provided to the Provider, at any time prior to Embryo Transfer or the death of either Intended Parent.

3. Intended Parent(s) entering into such agreements shall provide the Provider with an address and permanent identifier.

4. All such agreements must be delivered to the Providers and the ART Storage Facility, if any.

5. Any party to an Embryo storage or disposition agreement may withdraw his or her consent to the terms of the agreement in writing prior to an Embryo Transfer to a uterus of an Intended Parent, Gestational Surrogate, or Genetic Surrogate.

   (a) Notice of said withdrawal of consent to the terms of the agreement must be given in a Record to the parties to the agreement and to the Providers and ART Storage Facility, if any.

   (b) After receipt of said notice in a Record by the other Intended Parent and/or by the ART Provider or ART Storage Facility of that individual's intent to avoid Embryo Transfer, an Intended Parent may not Transfer the Embryos into the uterus of any individual with the intent to have a Child. No prior agreement to the contrary will be enforceable.

   (c) In the event that an Embryo Transfer occurs after receipt of notice in a Record of this Section that Intended Parent will not be the Parent of a resulting Child.

6. Following the death of an Intended Parent who has previously consented in a Record to posthumous use of cryopreserved Gametes and/or Embryos, the surviving Intended Parent or the individual designated in the Record to receive control of use of the Embryos may use the Embryos in accordance with the decedent's written consent in a Record. Except as otherwise provided in the enacting jurisdiction's probate code, the Child born as a result of Embryo Transfer after the death of an Intended Parent or Gamete Provider is not the Child of that Gamete Provider or Intended Parent unless the deceased individual consented in a Record that if Assisted Reproduction were to occur after death, the deceased individual would be a Parent of the Child.

7. No Provider shall Transfer or form any Embryos following the death of an Intended Parent unless the necessary consent referred to in paragraph 6 of this Section is obtained and permanently recorded.
8. In the event that a written agreement pursuant to paragraph 1 of this Section is not executed prior to Embryo formation, the Intended Parent[s] may execute an agreement consistent with this Section that may be enforceable on a prospective basis.

SECTION 502. DONATION OF UNUSED GAMETES OR EMBRYOS

Intended Parent(s) may choose to donate their unused Gametes or Embryos for any of the following purposes subject only to any limitations set forth in a Record prior to donation as permitted and imposed pursuant to the provisions of Section 204 hereof, which choices shall be reflected in their agreement(s):

1. Donation to another Patient(s), either known or anonymous, for the purpose of the recipient attempting to have a Child and become that Child’s Parent.

2. Donation for approved research, the nature of which may be specifically set forth in the informed consent Record and which has received the approval of an institutional review board. No research will be permitted that is not within the scope of the informed consent of the recorded agreement. This agreement may only be modified with the consent of the Intended Parent(s). After an Intended Parent has died, that individual’s consent endures and is irrevocable.

SECTION 503. SCREENING OF GAMETE OR EMBRYO DONORS

Donors shall be screened prior to such donation in compliance with applicable State and federal law in accordance with applicable medical standards. Records of the donation shall be maintained in compliance with applicable State and federal law.

SECTION 504. ABANDONMENT OF GAMETES OR EMBRYOS AND DISPOSITION OF ABANDONED GAMETES OR EMBRYOS

1. A Gamete or an Embryo is deemed to be abandoned only if:

   (a) At least five years have elapsed since last communication from Intended Parents to Provider and/or ART Storage Facility unless the Participants select another time by agreement as provided in a Record; and

   (b) A diligent attempt to notify the interested Participants, as well any Provider(s) who contracted for storage, that the Gamete or Embryo is deemed to be abandoned (such attempt shall include, but not be limited to, notice by certified mail (or equivalent trackable medium) to each interested Participant’s permanent address or last known address, and shall require a period of not less than ninety days to elapse before any action is taken); and

   (c) The interested Participants have acknowledged that they have been informed of the provisions of (a) and (b) of this paragraph in an agreement in a Record executed prior to storage with the Provider and/or ART Storage Facility.
2. Disposition of a Gamete or an Embryo deemed to be abandoned under paragraph 1 of this Section must be in accordance with the most recent recorded agreement between Participants and the ART Storage Facility. If there is no agreement in a Record, or if no agreement in a Record can be found after a diligent search, disposition must be as ordered by a Court.

3. Any Provider and/or ART Storage Facility that disposes of Gametes or Embryos in compliance with this Section is immune from all civil and criminal liability that may arise as a result of the disposition of such Gametes or Embryos, absent criminal intent, gross negligence, or intentional misconduct.

SECTION 505.  TRANSPORTATION OF GAMETES OR EMBRYOS

1. Transportation of Gametes or Embryos is the responsibility of the individual or individuals requesting the transport.

2. Unless the ART Storage Facility has requested or required transport, it is immune from all civil and criminal liability incurred as a result of the transport, absent criminal intent, gross negligence, or intentional misconduct.

ARTICLE 6. CHILD OF ASSISTED REPRODUCTION

SECTION 601.  SCOPE OF ARTICLE

This Article does not apply to the birth of a Child conceived by means of sexual intercourse, or as the result of a Surrogacy Agreement as provided in Article 7.

SECTION 602.  PARENTAL STATUS OF DONOR

A. A Donor is not a Parent of a Child conceived by means of Assisted Reproduction.

B. A determination that an individual is a Donor under paragraph (A) of this Section does not require proof of a written agreement or compliance with Articles 1 through 5 of this Act.

C. Donor Agreements Authorized.

1. A Gamete Donor and an Intended Parent(s) may enter into an agreement in a Record providing:

   (a) That the Donor agrees to donate Gametes in order for the Intended Parent(s) to conceive a Child through Assisted Reproduction; and
   (b) That the Donor, and spouse if married, has no property, parental, or other rights, responsibilities and claims with respect to any resulting Gametes, Embryos, and any Child born as a result of the Gamete donation;
(c) That any donated Gametes, and any Embryos formed from the donated 
Gametes, shall be the sole property and responsibility of the Intended 
Parent(s), subject to the terms of the Donor agreement; and 
(d) That the Donor is not a Parent of any Child conceived through Assisted 
Reproduction using the Donor’s gamete(s), and the Intended Parent(s) shall be 
the Child’s Parent(s) with all the rights and responsibilities resulting therefrom.

2. Any Donor limitations as noted in Section 204 should be specified in the Donor 
agreement.

SECTION 603. PARENTAGE OF CHILD OF ASSISTED REPRODUCTION

An individual who consents to Assisted Reproduction by an individual as provided in 
Section 604 with the intent to be a Parent of the Child is a Parent of the resulting Child. 
Compliance with Articles 1 through 5 of this Act is not required for a determination that an 
individual is a Parent under this Section.

SECTION 604. CONSENT TO ASSISTED REPRODUCTION

1. Except as otherwise provided in Section 604(2), the consent described in Section 603, 
must be in a Record signed by the individual giving birth to a Child conceived by Assisted 
Reproduction and any individual who intends to be a Parent of the Child.

2. Failure of an Intended Parent to sign a consent in a Record as required by paragraph 
1 of this Section, before or after birth of the Child, does not preclude a finding of parentage 
if:

(a) The individual seeking to establish that the Intended Parent is a Parent of the 
Child proves by clear-and-convincing evidence the existence of an express 
agreement entered into before conception that the Intended Parent and the 
individual who gave birth intended they both would be Parents of the Child; or 
(b) the individual giving birth and the individual alleged to be an Intended Parent 
resided together with the Child during the first two years of the Child’s life and 
openly held out the Child as their own, unless the individual dies or becomes 
incapacitated before the Child becomes two years of age or the Child dies before 
the Child becomes two years of age, in which case a court may find consent to 
parentage under this paragraph if a party proves by clear-and-convincing evidence 
that the individual giving birth and the individual intended to reside together in the 
same household with the Child and both intended that the individual would openly 
hold out the Child as the individual’s Child, but that the individual was prevented 
from carrying out that intent by death or incapacity.

SECTION 605. LIMITATION ON LEGAL SPOUSE’S DISPUTE OF PARENTAGE
1. Except as otherwise provided in Section 605(2), an individual, who at the time of a
Child’s birth, is the Legal Spouse of the woman who gave birth to the Child by Assisted
Reproduction, may not challenge the individual’s parentage of the Child unless:

   (a) Not later than two years after the birth of the Child, the individual commences
a proceeding to adjudicate the individual’s parentage of the Child; and

   (b) A Court finds the individual did not consent to the Assisted Reproduction,
before, on, or after birth of the Child, or withdrew consent under Section 606.

2. A proceeding to adjudicate a Legal Spouse’s parentage of a Child born by Assisted
Reproduction may be commenced at any time if the court determines the:

   (a) Legal Spouse neither provided a gamete for, nor consented to, the Assisted
Reproduction;

   (b) Legal Spouse and the woman who gave birth to the Child have not cohabited
since the probable time of Assisted Reproduction; and

   (c) Legal Spouse never openly held out the Child as the Legal Spouse’s Child.

3. This Section applies to a Legal Spouse’s dispute of parentage even if the Legal
Spouse’s marriage is declared invalid after Assisted Reproduction occurs.

SECTION 606. EFFECT OF DISSOLUTION OF MARRIAGE OR WITHDRAWAL
OF CONSENT

1. If a marriage is dissolved before an insemination or Embryo Transfer the former spouse
is not a Parent of the resulting Child unless the former spouse consented in a Record that
if Assisted Reproduction were to occur after a divorce, the former spouse would be a
Parent of the Child.

2. The consent of an individual to Assisted Reproduction may be withdrawn by that
individual in a Record with written notice to the individual undergoing Assisted
Reproduction at any time before an insemination or Embryo Transfer. An individual who
withdraws consent under this Section is not a Parent of the resulting Child.

SECTION 607. PARENTAL STATUS OF DECEASED INDIVIDUAL

Except as otherwise provided in the enacting jurisdiction’s probate code, if an individual
who consented in a Record to be a Parent by Assisted Reproduction dies before an
insemination or Embryo Transfer, the deceased individual is not a Parent of the resulting
Child unless the deceased spouse consented in a Record that if Assisted Reproduction
were to occur after death, the deceased individual would be a Parent of the Child.
ARTICLE 7. SURROGACY

SECTION 701. SURROGACY AGREEMENTS AUTHORIZED

A. A Gestational or Genetic Surrogate and, if married, the Gestational or Genetic Surrogate’s Legal Spouse and the Intended Parent(s) may enter into an agreement in a Record providing that:

1. The Gestational or Genetic Surrogate agrees to attempt pregnancy by means of Assisted Reproduction;

2. The Gestational or Genetic Surrogate and, if married, the Gestational or Genetic Surrogate’s Legal Spouse have no claims to parentage with respect to any Child resulting from the Assisted Reproduction procedure(s); and

3. The Intended Parent(s) shall be recognized as the sole Parent(s) of the Child.

B. A Surrogacy Agreement may provide for payment of consideration under Article 8 of this Act.

C. A Surrogacy Agreement may not limit the right of the Gestational or Genetic Surrogate to make any health and welfare decisions regarding the Surrogate and the Surrogate’s pregnancy. This Act does not enlarge or diminish the surrogate’s right to terminate or to continue the pregnancy.

D. A Genetic Surrogacy Agreement shall be subject to the following additional requirements and is enforceable only if:

1. Judicially validated as provided in Section 706; and

2. The Assisted Reproduction procedure(s) utilized to attempt a pregnancy are performed under the supervision of a licensed Physician.

SECTION 702. ELIGIBILITY

A. A Gestational or Genetic Surrogate shall be deemed to have satisfied the requirements of this Act if the Gestational or Genetic Surrogate has met the following requirements at the time the Surrogacy Agreement is executed and prior to the anticipated pregnancy. The Gestational or Genetic Surrogate:

1. Is at least twenty-one (21) years of age;

2. Has given birth to at least one (1) Child;

3. Has completed a Medical Evaluation relating to the anticipated pregnancy;
4. Has completed a Mental Health Evaluation relating to the anticipated Surrogacy Arrangement;

5. Is represented by Independent Legal Counsel and has undergone legal Consultation regarding the terms of the Surrogacy Agreement and the potential legal consequences of the Surrogacy Arrangement;

6. Has or will obtain a health insurance policy or other coverage for major medical treatments and hospitalization and the health insurance policy has a term that extends throughout the duration of the expected pregnancy and for eight (8) weeks after the birth of the Child.

B. The Intended Parent(s) shall be deemed to have satisfied the requirements of this Act if the Intended Parent(s) have met the following requirements at the time the Surrogacy Agreement is executed and prior to the anticipated pregnancy:

1. Intended Parent(s) have completed a Consultation relating to the anticipated Surrogacy Arrangement; and

2. Intended Parent(s) are represented by Independent Legal Counsel and have undergone legal Consultation regarding the same and the potential legal consequences of the Surrogacy Arrangement.

C. The relevant State regulatory agency may adopt rules pertaining to the required Medical Evaluations, Consultations and Mental Health Evaluations for a Surrogacy Agreement. Until the relevant State regulatory agency adopts such rules, Medical Evaluations, Consultations and Mental Health Evaluations and procedures shall be conducted in accordance with the recommended guidelines published by ASRM. The rules may adopt these guidelines or others by reference.

SECTION 703. REQUIREMENTS FOR A SURROGACY AGREEMENT

A. A Surrogacy Agreement is enforceable only if:

1. It meets the contractual requirements set forth in Section 703(B); and

2. It contains at a minimum each of the terms set forth in Section 703(C); and

3. If the Surrogacy Agreement is a Genetic Surrogacy Agreement, it must be judicially validated, as required by Section 706, prior to attempting pregnancy by means of Assisted Reproduction.

B. A Surrogacy Agreement shall meet the following requirements:

1. It shall be in writing;
2. It shall be executed prior to the commencement of any medical procedures in furtherance of the Surrogacy Arrangement (other than Medical Evaluations, Consultations or Mental Health Evaluations necessary to determine eligibility of the parties pursuant to Section 702 of this Act), by:

(a) A Gestational or Genetic Surrogate meeting the eligibility requirements of Section 702(A) of this Act and, if married, the Gestational or Genetic Surrogate’s Legal Spouse; and

(b) The Intended Parent(s) meeting the eligibility requirements of Section 702(B) of this Act.

3. The Gestational or Genetic Surrogate, and, if married, the Gestational or Genetic Surrogate’s Legal Spouse, and the Intended Parent(s) shall be represented by Independent Legal Counsel in all matters concerning the Surrogacy Arrangement and the Surrogacy Agreement;

4. Each of the parties acknowledge in writing that they received information about the legal, financial, and contractual rights, expectations, penalties, and obligations of the Surrogacy Agreement;

5. If the Surrogacy Agreement provides for the payment of Compensation to the Gestational or Genetic Surrogate, the Compensation shall be placed in escrow with an independent Escrow Agent prior to the Gestational or Genetic Surrogate’s commencement of any medical procedure (other than Medical Evaluations, Consultation or Mental Health Evaluations necessary to determine the Gestational or Genetic Surrogate’s eligibility pursuant to Section 702(A) of this Act); and

6. Each party’s signature shall be notarized or witnessed by two (2) competent adults who are not parties to the Surrogacy Agreement.

C. A Surrogacy Agreement shall provide for:

1. The express written agreement of the Gestational or Genetic Surrogate to:

(a) Undergo Assisted Reproduction procedure(s) to achieve a pregnancy and attempt to carry and give birth to a Child; and

(b) Surrender custody of any Child resulting from such Assisted Reproduction procedure(s) to the Intended Parent(s) immediately upon birth;

2. If the Gestational or Genetic Surrogate is married, the express agreement of the Gestational or Genetic Surrogate’s Legal Spouse to:
(a) Undertake the obligations imposed on the Gestational or Genetic Surrogate pursuant to the terms of the Surrogacy Agreement; and

(b) Surrender custody of any Child resulting from such Assisted Reproduction procedure(s) to the Intended Parent(s) immediately upon birth;

3. The right of the Gestational or Genetic Surrogate to utilize the services of a Physician chosen by the Gestational or Genetic Surrogate to provide care to the Gestational or Genetic Surrogate during the pregnancy; and

4. The right of the Gestational or Genetic Surrogate to make any health and welfare decisions regarding the Surrogate and the Surrogate’s pregnancy including continuation or termination of the pregnancy.

5. The express written agreement of the Intended Parent(s) to:

(a) Accept custody of any Child resulting from such Assisted Reproduction procedure(s) immediately upon birth regardless of number, gender, or mental or physical condition; and

(b) Assume sole responsibility for the support of the Child immediately upon birth.

6. Intended Parent(s) payment of reasonable legal, medical and/or ancillary expenses, including:

(a) The premiums for a health insurance policy that covers medical treatment and hospitalization for the Gestational or Genetic Surrogate unless otherwise mutually agreed upon by the parties, pursuant to the terms of the Surrogacy Agreement; and

(b) The payment of all uncovered medical expenses; and

(c) The payment of reasonable legal fees for the Gestational or Genetic Surrogate’s legal representation; and

(d) The payment of life insurance premiums; and

(e) Other reasonable financial arrangements mutually agreed upon by the parties, including any applicable reimbursement and compensation schedule, pursuant to the terms of the Surrogacy Agreement.
D. A court has jurisdiction to determine the Parent-Child Relationship pursuant to a Surrogacy Agreement where:

1. At least one of the parties to the Surrogacy Agreement is a resident; or
2. At least one of the medical procedures pursuant to the Surrogacy Agreement occurs; or
3. The birth occurs or is anticipated to occur.
4. If none of the above applies, the appropriate jurisdiction for determining the Parent-Child Relationship may be determined under the Uniform Child Custody Jurisdiction and Enforcement Act.

E. A Surrogacy Agreement is enforceable even if it contains one or more of the following provisions:

1. The Gestational or Genetic Surrogate's agreement to undergo all medical exams and/or treatments, and to follow activity restrictions, as instructed by the Physician for the success of the pregnancy (although there shall be no specific performance remedy for a breach of such provisions);
2. The agreement of the Intended Parent(s) to pay the Gestational or Genetic Surrogate reasonable Compensation;
3. The agreement of the Intended Parent(s) to pay for or reimburse the Gestational or Genetic Surrogate for reasonable expenses (including, without limitation, medical, legal, or other professional or necessary expenses) related to the Surrogacy Arrangement and to the Surrogacy Agreement.

SECTION 704. TERMINATION OF SURROGACY AGREEMENT

A. Prior to Pregnancy

1. Before a Gestational or Genetic Surrogate undergoes the Assisted Reproduction procedure(s) to attempt pregnancy, and subject to the terms of the Surrogacy Agreement, any party may terminate the Surrogacy Agreement by giving written notice of termination to all other parties.
2. No party may terminate the Surrogacy Agreement after an Embryo Transfer procedure and prior to a pregnancy test at a time to be determined by a qualified Physician.
3. Any party who terminates a Genetic Surrogacy Agreement after the appropriate Court issues an order validating a Genetic Surrogacy Agreement under Section 706 but before the Genetic Surrogate becomes pregnant by means of Assisted Reproduction.
Reproduction shall also file notice of the termination with the appropriate Court. On receipt of the notice, the appropriate Court shall order a stay on all medical procedures contemplated under the terms of the Genetic Surrogacy Agreement.

4. Except as otherwise agreed to among the parties in the Surrogacy Agreement, no party shall be liable to any other party for terminating the Surrogacy Agreement before the Gestational or Genetic Surrogate becomes pregnant by means of Assisted Reproduction.

B. After Pregnancy is confirmed.

1. Subject to the provisions of Section 714(C), no party may terminate a Surrogacy Agreement once a successful pregnancy is confirmed.

SECTION 705. ESTABLISHMENT OF PARENT CHILD RELATIONSHIP IN GESTATIONAL SURROGACY

A. RIGHTS OF PARENTAGE

1. Except as provided in this Act, a woman who gives birth to a Child is a Parent of that Child for purposes of State law.

2. The parties to a Gestational Surrogacy Agreement shall assume the rights and obligations of this Article if:

   (a) The Gestational Surrogate satisfies the eligibility requirements set forth in Section 702(A);

   (b) The Intended Parent(s) satisfy the eligibility requirements set forth in Section 702(B); and

   (c) The Gestational Surrogacy Agreement complies with the requirements of Section 703.

3. In the case of a Gestational Surrogacy Agreement satisfying the requirements set forth in this Article:

   (a) The Intended Parent(s) shall be the Parents of the Child for purposes of State law immediately upon the birth of the Child;

   (b) The Child shall be considered the Child of the Intended Parent(s) for purposes of State law immediately upon the birth of the Child;

   (c) Parental rights shall vest in the Intended Parent(s) immediately upon the birth of the Child;
(d) Sole custody of the Child shall rest with the Intended Parent(s) immediately upon the birth of the Child; and

(e) Neither the Gestational Surrogate nor the Gestational Surrogate’s Legal Spouse, if any, shall be the Parent of the Child for purposes of State law immediately upon the birth of the Child.

4. If the parentage of a Child born to a Gestational Surrogate is alleged not to be the result of the Assisted Reproduction procedure(s), the appropriate Court shall order genetic testing to determine the parentage of the Child. If the Child was not conceived as result of the Assisted Reproduction procedure(s), the Parent-Child Relationship shall be determined as provided under other applicable State law.

5. In the case of a Gestational Surrogacy Arrangement meeting the requirements set forth in this Section 705, in the event of a laboratory error in which the laboratory transfers Embryo(s) not legally belonging to the Intended Parent(s), the Intended Parents will be the Parents of the Child for purposes of State law unless otherwise determined by a Court in an action which can only be brought by one or more of the parties to the Surrogacy Agreement or the genetic contributors within two (2) years of the date of the Child’s birth.

B. ADMINISTRATIVE ESTABLISHMENT OF THE PARENT-CHILD RELATIONSHIP.

If an applicable State law provides for the administrative establishment of the Parent-Child Relationship, that process may be utilized by the parties for purposes of establishing a Parent-Child Relationship.

SECTION 706. ESTABLISHMENT OF PARENT CHILD RELATIONSHIP IN GENETIC SURROGACY

A. RIGHTS OF PARENTAGE

1. The parties to a Genetic Surrogacy Agreement shall assume the rights and obligations of paragraphs 2 and 3 of this Section 706(A) if:

   (a) The Genetic Surrogate satisfies the eligibility requirements set forth in Section 702(A);

   (b) The Intended Parent(s) satisfy the eligibility requirements set forth in Section 702(B); and

   (c) The Genetic Surrogacy Agreement complies with the requirements of Section 703 and has been judicially pre-approved prior to the
2. In the case of a Genetic Surrogacy Agreement satisfying the requirements set forth in paragraph 1 of this Section 706(A):

(a) The Intended Parent(s) shall be the Parents of the Child for purposes of State law immediately upon the birth of the Child;

(b) The Child shall be considered the Child of the Intended Parent(s) for purposes of State law immediately upon the birth of the Child;

(c) Parental rights shall vest in the Intended Parent(s) immediately upon the birth of the Child;

(d) Sole custody of the Child shall rest with the Intended Parent(s) immediately upon the birth of the Child; and

(e) Neither the Genetic Surrogate nor the Genetic Surrogate’s Legal Spouse, if any, shall be the Parent of the Child for purposes of State law immediately upon the birth of the Child.

3. In the case of a Genetic Surrogacy Arrangement meeting the requirements set forth in this Section 706, in the event of a laboratory error in which the laboratory transfers Embryo(s) not legally belonging to the Intended Parent(s), the Intended Parents will be the Parents of the Child for purposes of State law unless otherwise determined by a Court in an action which can only be brought by one or more of the parties to the Surrogacy Agreement or the genetic contributors within two (2) years of the date of the Child’s birth.

B. JUDICIAL PRE-APPROVAL OF GENETIC SURROGACY AGREEMENT

1. Prior to the commencement of any medical procedures in furtherance of the Genetic Surrogacy Arrangement (other than Medical Evaluations, Consultation or Mental Health Evaluations necessary to determine eligibility of the parties pursuant to Section 702 of this Act), the Intended Parent(s), the Genetic Surrogate, and Genetic Surrogate’s Legal Spouse, if any, shall commence a proceeding to obtain judicial pre-approval of a Genetic Surrogacy Agreement by filing a petition in the appropriate Court. A proceeding to obtain judicial pre-approval of a Genetic Surrogacy Agreement may not be maintained unless all parties to the Genetic Surrogacy Agreement join in the petition. A copy of the fully-executed Genetic Surrogacy Agreement must be filed with the petition.
2. If the requirements of paragraph 1 of this Section 706(B) are satisfied, the appropriate Court shall issue an order validating the Genetic Surrogacy Agreement and declaring that the Intended Parent(s) will, subject to the issuance of a final post birth order, be the sole Parent(s) of a Child born during the term of the Genetic Surrogacy Agreement.

3. The Court shall issue an order under this Section 706(B) only on finding that:

   (a) The requirements of Section 702 have been satisfied;
   (b) The requirements of Section 706(B) have been satisfied;
   (c) All parties have voluntarily entered into the Genetic Surrogacy Agreement meeting the requirements of Section 703 and understand its terms;
   (d) Adequate provision has been made for all reasonable health-care expenses associated with the Genetic Surrogacy Agreement, including responsibility for those expenses if the Genetic Surrogacy Agreement is terminated, as set forth in Section 703(C)(6); and
   (e) The consideration, if any, to be paid to the Genetic Surrogate is reasonable.

C. PARENTAGE UNDER A JUDICIALLY PRE-APPROVED GENETIC SURROGACY AGREEMENT

1. Upon birth of a Child pursuant to a judicially pre-approved Genetic Surrogacy Agreement, all parties shall jointly file a notice with the appropriate Court that a Child has been born as a result of the Assisted Reproduction procedure(s). Thereupon, the appropriate Court shall issue an order:

   (a) Confirming that the Intended Parent(s) are the Parent(s) of the Child;
   (b) If necessary, ordering that the Child be surrendered to the Intended Parent(s); and
   (c) Directing the agency maintaining birth records to issue a birth certificate naming the Intended Parent(s) as Parent(s) of the Child on an expedited basis.

2. If the parentage of a Child born to a Genetic Surrogate is alleged not to be the result of the Assisted Reproduction procedure(s), the appropriate Court shall order genetic testing to determine the parentage of the Child. If the Child was not conceived as result of the Assisted Reproduction procedure(s), the Parent-
Child Relationship shall be determined as provided under other applicable State law.

3. If the parties fail to comply with paragraph 1 of this Section 706(C), the appropriate State agency may, upon request of any party, file notice with the appropriate Court that a Child has been born to the Genetic Surrogate as a result of Assisted Reproduction. Upon proof of a Court order issued pursuant to Section 706(B) validating the Genetic Surrogacy Agreement, the appropriate Court shall order that the Intended Parent(s) are the sole legal Parent(s) of the Child and are financially responsible for the Child.

4. If a birth results under a Genetic Surrogacy Agreement that is not judicially pre-approved as provided in this Section 706, the Parent-Child Relationship shall be determined as provided under other applicable State law specifically taking into consideration the intent of the parties at the time of the execution of the Genetic Surrogacy Agreement and the best interests of the Child. An Intended Parent has standing to request and be awarded legal parentage of the Child for the purposes of this provisions and any parentage proceeding hereunder.

SECTION 707. FULL FAITH AND CREDIT

An establishment of parentage pursuant to an order of Court under Section 705 (A) or 706 of this Act shall be given full faith and credit in another State if the establishment was in a signed Record and otherwise complies with the law of the other State.

SECTION 708. DUTY TO SUPPORT

A. Any individual who is considered to be the Parent of the Child pursuant to Section 705 or Section 706 of this Act shall be obligated to support the Child.

B. Intended Parents who are parties to a non-compliant Gestational Surrogacy Arrangement or an unapproved Genetic Surrogacy Agreement may be held liable for support of the resulting Child under other law.

C. Breach of the Surrogacy Agreement by the Intended Parent(s) shall not relieve such Intended Parent(s) of the support obligations imposed by this Act.

SECTION 709. EFFECT OF SURROGATE’S SUBSEQUENT MARRIAGE

A. Gestational Surrogacy

Subsequent marriage of the Gestational Surrogate after execution of a Surrogacy Agreement under this article does not affect the validity of the Surrogacy Agreement, consent to the Surrogacy Agreement from the Gestational Surrogate’s Legal Spouse is not required, and the Gestational Surrogate’s Legal Spouse is not a presumed Parent of the resulting Child.
B. Genetic Surrogacy

After the issuance of an order validating a Surrogacy Agreement between Intended Parents and a Genetic Surrogate under this article, subsequent marriage of the Genetic Surrogate does not affect the validity of a Surrogacy Agreement, consent to the Surrogacy Agreement from the Genetic Surrogate’s Legal Spouse is not required, and the Genetic Surrogate’s Legal Spouse is not a presumed Parent of the resulting Child.

SECTION 710. IRREVOCABILITY

No action to challenge the rights of parentage established pursuant to Section 705 or Section 706 of this Act or the relevant State parentage act provisions shall be commenced after twelve (12) months from the date of birth of the Child.

SECTION 711. NONCOMPLIANCE

Noncompliance occurs when a Gestational or Genetic Surrogate, and, if married, the Gestational or Genetic Surrogate’s Legal Spouse, or the Intended Parent(s) breach a provision of the Surrogacy Agreement or any party to or agreement for a Surrogacy Arrangement fails to meet any of the requirements of this Act.

SECTION 712. EFFECT OF NONCOMPLIANCE

In the event of noncompliance with this Article, the appropriate Court of competent jurisdiction shall determine the respective rights and obligations of the parties to any Surrogacy Arrangement based solely on evidence of the parties’ original intent.

SECTION 713. IMMUNITIES

Except as provided in this Act, no individual shall be civilly or criminally liable under State law for non-negligent actions taken pursuant to the requirements of this Act. This provision shall not prevent liability or actions between or among the parties, including actions brought by or on behalf of the Child, based on negligent, reckless, willful, or intentional acts that result in damages to any party.

SECTION 714. DAMAGES

A. Except as expressly provided in the Surrogacy Agreement, the Intended Parent(s) shall be entitled to all remedies available at law or equity in the event of a breach of the Surrogacy Agreement.

B. Except as expressly provided in the Surrogacy Agreement, a Gestational or Genetic Surrogate shall be entitled to all remedies available at law or equity in the event of a breach of the Surrogacy Agreement.
C. There shall be no specific performance remedy available for a breach by a Gestational or Genetic Surrogate of a Surrogacy Agreement that:

1. Limits the right of the Gestational or Genetic Surrogate to make decisions regarding the Gestational or Genetic Surrogate’s own health or pregnancy;

2. Forces the Gestational or Genetic Surrogate to undergo Assisted Reproduction for the purposes of becoming pregnant; or

3. Requires or prevents a Gestational or Genetic Surrogate from terminating the pregnancy.

SECTION 715. INSPECTION OF RECORDS

The proceedings, records, and identities of the individual parties to a Surrogacy Agreement under this Article are subject to inspection by the parties and their attorneys of record under the standards of confidentiality applicable to adoptions as provided under other law of this State.

SECTION 716. EXCLUSIVE, CONTINUING JURISDICTION

During the period governed by the Surrogacy Agreement, the Court conducting a proceeding under this Act has exclusive, continuing jurisdiction of all matters arising out of the Surrogacy Agreement until the Child, delivered by the Gestational or Genetic Surrogate during the term of the Surrogacy Agreement, attains the age of ninety (90) days; however, nothing in this provision gives the Court jurisdiction over a child custody or a child support action where such jurisdiction is not otherwise authorized.

ARTICLE 8. PAYMENT TO DONORS AND GESTATIONAL OR GENETIC SURROGATES

SECTION 801. REIMBURSEMENT

1. A Donor may receive reimbursement for economic losses resulting from the Retrieval or storage of Gametes or Embryos and incurred after the Donor has entered into a valid agreement in a Record to be a Donor.

2. Economic losses occurring before a Donor, Gestational Surrogate or Genetic Surrogate has entered into valid agreement in a Record may not be reimbursed unless subsequently agreed upon in the agreement, except as provided for in paragraph 3 of this Section.

3. Premiums paid for insurance against economic losses directly resulting from the Retrieval or storage of Gametes or Embryos for donation may be reimbursed, even if such premiums have been paid before the Donor has entered into a valid agreement in a
Record, so long as such agreement becomes valid and effective before the Gametes or Embryos are used in Assisted Reproduction in accordance with the agreement.

SECTION 802. COMPENSATION

1. The Compensation, if any, paid to a Donor, Gestational Surrogate, or Genetic Surrogate must be reasonable according to industry standards and negotiated in good faith between the parties.

2. Compensation may not be conditioned upon the quantity, purported quality or genome-related traits of the Gametes or Embryos.

3. Compensation may not be conditioned on actual genotypic or phenotypic characteristics of the Donor or of the Child.

ARTICLE 9. HEALTH INSURANCE

SECTION 901. INFERTILITY AND EXPERIMENTAL PROCEDURES

1. The ASRM or other appropriate governmental regulatory authority may designate, from time to time, a list of ART procedures and treatments considered to be experimental.

SECTION 902. REQUIRED NOTICE

1. Each group health benefit plan that offers assisted reproductive health services shall provide notice in a Record to each enrollee in the plan of the specific coverage provided for those services.

2. The notice required under this Section must be prominently positioned in any literature, insurance application, or insurance policy plan description made available or distributed by the group health benefits plan to enrollees.

SECTION 903. QUALIFICATION OF PROVIDERS

A health insurer may require that any licensed Physician participating in the treatment of Infertility must be:

(a) Board certified in Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology and have a practice comprised substantially of Infertility cases; or

(b) Board certified in both Obstetrics and Gynecology and in Reproductive Endocrinology by the American Board of Obstetrics and Gynecology, with a practice comprised substantially of Infertility cases; or
(c) Board certified in both Andrology and Urology by the American Board of Urology.

ARTICLE 10. QUALITY ASSURANCE

SECTION 1001. QUALIFICATIONS OF PROVIDERS

1. ART Providers and ART Storage Facilities (hereafter “Program”) shall assure the quality of their services by developing and complying with at least the following quality assurance measures:

(a) Personnel. The Program shall document that senior and supervisory staff are adequately trained, including formal training in genetics. Documentation shall also include staff participation in laboratory training programs and regular updating of staff skills and knowledge.

(b) Equipment. The Program shall develop, implement, and test regularly backup and contingency plans for cryopreservation systems, computer systems, and records.

(c) Testing. The Program shall use a laboratory that participates in proficiency testing and on-site inspection, in compliance with the requirements for certification promulgated by the State Department of Health, if any. If genetic diagnostic services are provided, the Program or the laboratory shall comply with the applicable guidelines of organizations otherwise recognized by ASRM, such as the College of American Pathologists and the American College of Medical Genetics.

SECTION 1002. COLLABORATIVE REPRODUCTION REGISTRIES

1. Collaborative Reproduction registries (or equivalent) created for the purpose of maintaining contact, medical, and psychosocial information about Donors, Gestational or Genetic Surrogates, and Children born as a result of ART, or to benefit the public health, operating within this jurisdiction shall incorporate, at a minimum, the following elements:

(a) Establish procedures to allow the disclosure of non-identifying information, while protecting the anonymity of Donors;

(b) Establish procedures to allow the disclosure of identifying information about Participants only if mutual consent of all parties affected is obtained prior to the release of such information;

(c) Maintain medical and genetic information and updated current health information, including change in health status, about the Donor; Donors or Providers are not required to update such information unless required by written agreement;
(d) Establish procedures to allow disclosure of non-identifying medical and psychosocial information to the resulting Child;

(e) Establish whether a resulting Child is authorized to contact a program; and

(f) Retain all records involving third party reproduction until the resulting Child has reached the age of 40.

2. Health care Providers in this jurisdiction shall not utilize registries that fail to comply with the requirements of paragraph 1 of this Section, except as may be otherwise required or permitted by federal or State law.

SECTION 1003. HEALTH INFORMATION MANAGEMENT

1. The Program shall maintain all records in compliance with State and Federal law.

2. The Provider:

   (a) Shall attempt to maintain, contact information, including an address, of the Participants for contact by Patients, resulting Children, and Participants;

   (b) Shall participate in a national Donor and Collaborative Reproduction registry, if established as described in Section 1002 of this Act, so that Intended Parents and Donors can provide the program with address information;

   (c) Shall participate in a national Donor and Collaborative Reproduction registry, if established as described in Section 1002 of this Act, by collecting medical and genetic information and updated current health information, including change in health status of the Donor; and

   (d) Shall maintain an accurate record of the disposition of all Gametes and Embryos.

3. The Program shall transfer all records involving Collaborative Reproduction to a national Donor and Collaborative Reproduction registry in compliance with its requirements, if established as described in Section 1002 of this Act.

4. Disclosure of Medical Information.

   (a) Medical Information may be disclosed to an interested party or resulting Child only if an authorization is provided in accordance with applicable law;

   (b) The Program may disclose aggregate, non-identifiable data for quality assurance and reporting requirements, for the limited purpose of:
(i) Ensuring a standard for the maintenance of records on laboratory tests and procedures performed, including safe sample disposal;

(ii) Maintaining records on personnel and facilities, schedules of preventive maintenance; and

(iii) Ensuring minimum qualification standards for personnel.

SECTION 1004. PATIENT SAFETY

The program shall:

1. Conduct medical testing for sexually transmitted diseases in Gamete Providers, whether Donors or Intended Parents, and Gestational and Genetic Surrogates in compliance with the laws and regulations of or applying to appropriate governmental regulatory authorities; and

2. Conduct medical screening and genetic testing of Gamete and Embryo Donors for genetic disorders. The extent of such screening shall be in conformity with guidelines established by the ASRM. In the event that no such guidelines have been developed, the screening shall be in accordance with accepted standards of medical practice for ART Providers.

3. Establish procedures for the proper labeling of Embryos and Gametes in compliance with the laws and regulations of or applying to appropriate governmental regulatory authorities.

ARTICLE 11. ENFORCEMENT

SECTION 1101. DAMAGES

1. The failure of a Provider to comply with this Act shall constitute unprofessional conduct and may be reported to any controlling licensing authority.

2. In addition to other remedies available at law, including but not limited to causes of action under HIPAA, a Participant whose confidential information has been used or disclosed in violation of this Act and who has sustained economic loss or personal or emotional injury therefrom may recover compensatory damages, reasonable attorney's fees, and the costs of litigation.

3. Failure to account for all Embryos, misuse of Embryos, theft of Embryos, or unauthorized disposition of Embryos may subject a Provider or ART Storage Facility to criminal and civil penalties, including punitive damages, and reasonable legal fees to the prevailing party.
4. Any individual or entity not acting in accordance with this Act may be subject to civil and/or criminal liability.

ARTICLE 12. MISCELLANEOUS PROVISIONS

SECTION 1201. LIMITATION OF MEDICAL PROFESSIONAL LIABILITY

1. Licensed Providers rendering services in compliance with practice and ethical guidelines (contemporaneous to the time of alleged breach of the standard of care) or applicable State or federal regulations or statutes are presumed to have rendered care within accepted standards of care.

SECTION 1202. SEVERABILITY

The invalidation of any part of this Act by a court of competent jurisdiction shall not result in the invalidation of any other part.
Introduction & Summary

This ABA Model Act Governing Assisted Reproduction [2019] ("Model Act [2019]") was developed by the American Bar Association Section of Family Law to replace the ABA Model Act Governing Assisted Reproductive Technology (2008) ("Model Act [2008]").

Significant social, legal, and medical advancements require modernization of the provisions of the Model Act [2008]. Many changes in the form, makeup, and reality of modern families affect how we form parental relationships and impose support obligations. Advances in medicine continue to expand the options for and genetic nuances of intended parents and their resulting children. To keep up with the modern realities of assisted reproductive technology and the modern realities of how families are formed, the Model Act must be updated as well.

The Section of Family Law circulated the substantive draft documents to the following ABA entities, who were also invited to take part in working group sessions for review and feedback: Section of Business Law; Section of Civil Rights and Social Justice; Section of Health Law; Section of International Law; Section of Litigation, Real Property, Trust and Estate Law; Section of Science and Technology Law; the Solo, Small Firm and General Practice Division; Section of Tort, Trial and Insurance Practice; the Young Lawyers Division; and the ABA Commission on Sexual Orientation and Gender Identity. The draft documents were also circulated to the following additional non-ABA entities who also participated in working group sessions to review and provide additional feedback: National Center for Lesbian Rights; National LGBT Bar Association; and the Uniform Law Commission. Many of these groups were active participants in the development of the Model Act [2019].

That there is a need for such uniform legislation is expressed clearly in an appellate decision involving a dispute about parentage:

We join the chorus of judicial voices pleading for legislative attention to the increasing number of complex legal issues spawned by recent advances in the field of assisted reproduction. Whatever merit there may be to a fact-driven case-by-case resolution of each new issue, some over-all legislative guidelines would allow the participants to make informed choices and the courts to strive for uniformity in their decisions.” In re Marriage of Buzzanca, 61 Cal.App.4th 1410, 1428-29, 72 Cal. Rptr. 280 (Cal.App. 1998).

Background

The Model Act [2008] provided a framework to resolve contemporary controversies over parentage via assisted reproduction, a framework to resolve controversies yet to
come but that were envisioned by the advancement in assisted reproductive technology, and a framework to guide the expansion of ways by which families are formed. See https://www.americanbar.org/content/dam/aba/publishing/family_law_quarterly/family_flq_artmodelact.authcheckdam.pdf.

However, in 2015, the U.S. Supreme Court ruled in Obergefell v. Hodges, 135 S. Ct. 2584 (2015), that marriage is a fundamental right guaranteed to same-sex couples by both the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the U.S. Constitution. This advancement of marital rights for same-sex couples in and of itself dictates that the Model Act [2008] be modernized to remove gender- and sexual-orientation-based references. Courts around the country have already begun to expand the definition of parentage in light of Obergefell. Accordingly, the provisions of the Model Act [2008] must be replaced with gender-neutral definitions and language throughout to insure equal treatment of those children born through assisted reproduction to same-sex couples.

Additionally, the Model Act [2008] sections dealing with parentage were intended, as much as possible, to be consistent with and to track the corresponding provisions of the Uniform Parentage Act (“UPA”)\(^1\). The UPA addresses a wide variety of parentage issues, including parentage via assisted reproduction. However, the UPA as amended in 2002 was never widely adopted; only two of the eleven states that adopted the UPA (2002) to date adopted the Article 8 provisions governing surrogacy, and five of those eleven states enacted alternative regulatory schemes for surrogacy that are not based on the UPA. Likewise, since 2008, several other states have enacted surrogacy legislation, which borrowed only minimally from the UPA and the Model Act [2008]. This suggests that the substance of both the UPA and Model Act [2008] are not necessarily a preferred method of regulating surrogacy arrangements and that those provisions should be updated to make them more consistent with current surrogacy practice. The UPA was significantly updated in 2017, and as of the date of this Report, has been enacted in three states (California, Vermont and Washington State). The Model Act [2019] provides similarly significant updates to replace the Model Act [2008].

Finally, according to the last success rate updates issued by the Centers for Disease Control and Prevention on February 24, 2016, 1.6 percent of all infants born in the United States each year are conceived using assisted reproductive technology (ART). Thus, it is important to replace the Model Act [2008] to address the issue of the resulting children’s right to access information about their gamete (sperm or egg) donor.

**Major Overhaul to the Model Act [2008] Provided by Model Act [2019]**

\(^1\) The Uniform Parentage Act is a uniform act originally promulgated in 1973 by the National Conference of Commissioners of Uniform State Laws (now known as the Uniform Law Commission). It has since been amended and the most recent changes are reflected in the UPA (2017) approved by the ABA House of Delegates in February 2018. Where the subjects of parentage and assisted reproduction overlap, the Model Act [2019] tracks the relevant provisions of the UPA (2017) with some differences in regard to Genetic Surrogacy. Likewise, Sections 402, 605 and other select portions of this Model Act [2019] were taken directly from the Uniform Parentage Act (2017).
With this background in mind, the major revisions to the Model Act [2008] are as follows:

1. **Model Act [2019] includes new definitions and gender/sexual orientation neutral language throughout the Act** – New defined terms have been added to the Model Act [2019] and definitions have been updated throughout to allow for gender-neutral terminology. These updates leave behind the outdated notion that families are created only by two, heterosexual parents, and render the Act equally applicable to children of all individuals building families through ART.


4. **Model Act [2019] Adds Parental Establishment Provisions via Traditional/Genetic Surrogacy Which Were Not Addressed in the 2008 Act** - The Model Act [2019] substitutes “genetic surrogate” (a surrogate who contributes the surrogate’s own eggs in a surrogacy arrangement) for the more commonly used, but vague, term “traditional surrogate.” Addressing parentage through genetic surrogacy for the first time, the Model Act [2019] requires a judicial pre-approval process for genetic surrogacy along with a final, post-birth order confirming parentage assuming all parties are still in agreement. If agreement between the parties is lacking, or compliance with the Act is lacking, the Model Act [2019] requires parentage to be determined in accordance with existing parentage presumptions and procedures under applicable state law. Further, the provisions of the Model Act [2019] provide intended parents a right to reimbursement and/or damages if a surrogate breaches the surrogacy agreement.

5. **Model Act [2019] Includes Baseline Best Practice and Eligibility Requirements for all Surrogacy** - The Model Act [2019] also includes best-practice baseline requirements for both types of surrogacy in regard to eligibility and proper medical screening and education for surrogates and intended parents, as well as establishing foundational requirements that must be present in written surrogacy agreements.

Note regarding the Consultations and Mental Health Evaluations required in Collaborative Reproduction: The American Society for Reproductive Medicine (“ASRM”), continues to study, promulgate and update clear best practice and ethical guidelines for assisted reproduction as the practice around collaborative and assisted reproduction have grown and changed. In particular, ASRM provides
the latest recommendations for evaluation of surrogates and intended parents, incorporating information from the Centers for Disease Control, National Institutes of Health and the U.S. Food and Drug Administration among others. These guidelines include screening and testing for intended parents and surrogates to reduce the possibility of complications, to reduce the spread of infectious diseases and to address the complex medical and psychological issues that confront the parties, as well as the resulting children. The guidelines represent an effort to make the screening procedures for parties involved in third-party reproduction more consistent as well.

According to ASRM, “the decision to use a gestational carrier is complex, and patients and their partners (if applicable) 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. Psychosocial evaluation and counseling by a qualified mental health professional is also strongly recommended for all potential carriers and their partners. The education and counseling should include a clinical interview and, where appropriate, psychological testing. Psychological test data should be handled in accordance with American Psychological Association ethical standards. See “Recommendations for practices utilizing gestational carriers: a committee opinion”; Fertility and Sterility® Vol. 107, No. 2, February 2017 0015-0282.

Conclusion

The Model Act Governing Assisted Reproduction [2019] seeks to bring current parentage law up to speed with social, legal, and medical advancements and is a necessary step in the right direction in preparing for the future of parentage law.

Respectfully submitted,

Melissa Avery
Chair, Section of Family Law
January 2019
GENERAL INFORMATION FORM

Submitting Entity: Section of Family Law

Submitted By: Melissa Avery, Chair, Section of Family Law

1. **Summary of Resolution(s).** The Resolution adopts the Model Act Governing Assisted Reproduction [2019], dated January 2019, as an appropriate Act for those states desiring to adopt the specific substantive law contained in the Act.

2. **Approval by Submitting Entity.** The ABA Section of Family Law approved submission of this Resolution on November 7, 2018.

3. **Has this or a similar resolution been submitted to the House or Board previously?** Yes, this Resolution was previously submitted for the 2018 Midyear and Annual Meetings and was subsequently withdrawn to address further comments from interested sections of the ABA and entities outside the ABA.

4. **What existing Association policies are relevant to this Resolution and how would they be affected by its adoption?** The ABA Model Act Governing Assisted Reproduction Technologies [2008] (“Model Act [2008]”) was adopted by the ABA House of Delegates in 2008 (“Resolution 107”). See 2008M107. First, social, legal, and medical advancements in the area of assisted reproductive technologies (“ART”) require modernization of the Model Act [2008]. These include making the language neutral as to gender- and sexual-orientation to ensure equal treatment of those children born through assisted reproduction to same-sex couples. Second, the Model Act [2008] aimed to be consistent with and to track the corresponding provisions of the Uniform Parentage Act (“UPA”) (2000), as amended in 2002. As the UPA (2002) provisions regulating surrogacy arrangements and ART-parentage have recently been updated for consistency with current practice, so too have the Model Act provisions. Finally, the proposed revisions address the issue of the resulting children’s right to access information about their gamete (sperm or egg) donor. This Model Act [2019] addresses those issues and is intended to replace the Model Act [2008].

5. **If this is a late report, what urgency exists which requires action at this meeting of the House?** Not Applicable.

6. **Status of Legislation.** (If applicable). Not Applicable.

7. **Brief explanation regarding plans for implementation of the policy, if adopted by the House of Delegates.** If adopted, the Family Law Section, with the assistance of its Assisted Reproductive Technologies Committee, intends to submit the Model Act [2019] as an appropriate Act for those states desiring to adopt the specific substantive law contained in the Act.

8. **Cost to the Association.** (Both direct and indirect costs). None
9. **Disclosure of Interest.** (If applicable). Not Applicable.

10. **Referrals.** The Section of Family Law circulated the substantive draft documents to the following ABA entities, who were also invited to take part in Working Group sessions in June 2017 and February, March and April of 2018, and August, September and October of 2018:

   a. Section of Business Law;
   b. Section of Civil Rights and Social Justice;
   c. Commission on Sexual Orientation and Gender Identity;
   d. Section of Health Law;
   e. Section of International Law;
   f. Section of Litigation;
   g. Section of Real Property, Trust and Estate Law;
   h. Section of Science and Technology Law;
   i. Solo, Small Firm and General Practice Division;
   j. Section of Tort, Trial and Insurance Practice;
   k. Young Lawyers Division;
   l. National Center for Lesbian Rights;
   m. National LGBT Bar Association; and
   n. Uniform Law Commission.

11. **Contact Name and Address Information.** (Prior to the meeting. Please include name, address, telephone number and e-mail address).

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12. **Contact Name and Address Information.** (Who will present the report to the House? Please include name, address, telephone number, cell phone number and e-mail address.)

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EXECUTIVE SUMMARY

1. **Summary of the Resolution**

2. **Summary of the Issue that the Resolution Addresses**
   The Section of Family proposes the Model Act [2019] to replace the Model Act Governing Assisted Reproductive Technology [2008] ("Model Act [2008]") previously approved by the House of Delegates. First, social, legal, and medical advancements in the area of assisted reproductive technologies ("ART") require modernization of the Model Act [2008]. These include making the language neutral as to gender- and sexual-orientation to insure equal treatment of those children born through assisted reproduction to same-sex couples. Second, the Model Act [2008] aimed to be consistent with and to track the corresponding provisions of the Uniform Parentage Act ("UPA") (2000), as amended in 2002. The UPA (2002) provisions regulating surrogacy arrangements and ART-parentage have recently been updated by the UPA (2017) for consistency with current practice; so too have the Model Act provisions. Finally, the proposed revisions address the issue of the resulting children’s right to access information about their gamete (sperm or egg) donor.

3. **Please Explain How the Proposed Policy Position will address the issue**
   The Model Act [2019] includes new defined terms and updated definitions throughout to allow for gender-neutral terminology, updates provisions regulating surrogacy arrangements and Assisted Reproduction-parentage for consistency with current practice and addresses children’s right to access information about their gamete (sperm or egg) donor. The Model Act [2019] brings current parentage law up to speed with social, legal, and medical advancements and is a necessary step in the right direction in preparing for the future of parentage law.

4. **Summary of Minority Views**
   Concerns raised by the Sections of Health Law, Science and Technology and Real Property, Trusts and Estates as well as the ABA Commission on Sexual Orientation and Gender Identity, the National Center for Lesbian Rights, the National LGBT Bar Association and the Uniform Law Commission were addressed in substantive working group meetings. Otherwise, the sponsors are aware of no other minority views, opposition or concerns with the Resolution.