

AMERICAN BAR ASSOCIATION MODEL ACT GOVERNING ASSISTED REPRODUCTIVE TECHNOLOGY (February 2008)

PREFATORY NOTE

This proposed Model Act is the work of the American Bar Association Section of Family Law's Committee on Reproductive and Genetic Technology. It has been approved by the Section Council. The sections dealing with parentage are intended, as much as possible, to be consistent with and to track the corresponding provisions of the Uniform Parentage Act of 2000, as amended in 2002.

Since the birth of the first in vitro fertilization (IVF) baby in 1978, extraordinary advances in reproductive medicine have made biological parenthood possible for people with infertility, certain other medical conditions, for individuals who risk passing on inheritable diseases or genetic abnormalities, or for individuals who are effectively infertile due to social rather than medical reasons. Such advances have also been applied to extend reproductive potential by treating post-menopausal women. These advances use technology to enable individuals to have children when for personal reasons they cannot or choose not to do so by means of sexual intercourse. These advances have also been used to retrieve gametes from dead or incapacitated individuals, or to manipulate differentiated cells to produce the equivalent or near-equivalent of a human embryo, capable of implantation in the uterus and gestation to term birth.

The rise of these new technologies and therapeutic modalities, including the use of third parties, to assist in creation or gestation of an embryo has created a host of novel legal issues. The resolution of these issues has caused confusion and contradictions in the application of a body of existing statutory and common law. It is the purpose of this Act to give assisted reproductive technology (ART) patients, participants, parents, providers, and the resulting children and their siblings clear legal rights, obligations and protections. These goals are accomplished by establishing legal standards for the use, storage, and other disposition of gametes and embryos by addressing societal concerns about ART, such as clarifying issues of health insurance coverage for the treatment of infertility and by establishing legal standards for informed consent, reporting, and quality assurance.

The Act provides a flexible framework that will serve as a mechanism to resolve contemporary controversies, to adapt to the need for resolution of controversies that are envisioned but that may have not yet occurred, and to guide the expansion of ways by which families are formed. That there is a need for such legislation has perhaps not been expressed any better than 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).

The Section of Family Law, in conjunction with other ABA entities and medical professional organizations, including the American Society of Reproductive Medicine (ASRM) and Society of Assisted Reproductive Technology (SART), plans and intends to supplement this Act with a statement of necessary provisions and standards of best practice for drafting the informed consents and various ART agreements suggested or required by this Act and, to the extent possible, develop model forms.

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SECTION 101. SHORT TITLE

This Act is entitled a Model Act Governing Assisted Reproductive Technology.

SECTION 102. DEFINITIONS

1. “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 insemination;
- (b) Donation of eggs;
- (c) Donation of embryos;
- (d) In-vitro fertilization and transfer of embryos; and
- (e) Intracytoplasmic sperm injection.

2. “Assisted reproductive technology” (ART) is any medical or scientific intervention, including assisted reproduction, provided for the purpose of achieving live birth that results from assisted conception. Assisted conception means the formation of a human embryo with the intent to produce a live birth.

3. “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.

4. “Child” means a live born individual of any age whose parentage may be determined under this Act or other law.

5. “Collaborative reproduction” involves any assisted reproduction in which a individual other than the intended parent(s) provides genetic material or agrees to act as a gestational carrier. It can include, but is not limited to, (1) attempts by intended parents to create a child through means of a gestational agreement, with or without the involvement of donors, and (2) assisted reproduction involving donors where a gestational carrier is not used.

6. “Compensation” means payment of any valuable consideration for time, effort, pain and/or risk to health in excess of reasonable medical and ancillary costs.

7. “Consultation” means an initial in-person meeting with a licensed mental health professional for the purpose of educating the participants about the effects and potential consequences of their participation in any ART procedure.

8. “Counseling” means additional consultation(s) after the initial consultation for the purpose of advising and supporting the participant during the implementation of any ART procedure.

9. “Donor” means an individual who produces eggs or sperm used for assisted reproduction, whether or not for consideration. 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. Embryo donor means an individual or individuals with dispositional control of an embryo who provide(s) it to another for gestation and relinquish(es) all present and future parental and inheritance rights and obligations to a resulting individual or individuals.

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

11. “Embryo transfer” means all medical and laboratory procedures that are necessary to effectuate the transfer of an embryo into the uterine cavity.

12. “Experimental procedure” means any procedure for which there is inadequate evidence of safety and efficacy.

13. “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.

14. “Gamete provider” means an individual who provides sperm or eggs for use in assisted reproduction.

15. “Gestational agreement” is a contract between intended parents and a gestational carrier intended to result in a live birth.

16. “Gestational carrier” means an adult woman, not an intended parent, who enters into a gestational agreement to bear a child, whether or not she has any genetic relationship to the resulting child. Both a traditional surrogate (a woman who undergoes insemination and fertilization of her own eggs *in vivo*) and a gestational surrogate (a woman into whom an embryo formed using eggs other than her own is transferred) are gestational carriers.

17. “Gestational carrier arrangement” means the process by which a woman attempts to carry and give birth to a child created through in vitro fertilization using the gamete or gametes of at least one of the intended parents and to which the gestational carrier has

made no genetic contribution. [This paragraph applies only to Alternative “B” of Section 7].

18. “Infertility treatment” means any medical treatment reasonable and necessary for an intended parent to achieve a live birth.

19. “Intended parent” is an individual, married or unmarried, who manifests the intent as provided in this Act to be legally bound as the parent of a child resulting from assisted or collaborative reproduction.

20. “In vitro fertilization” means the formation of a human embryo outside the human body.

21. “Legal spouse” means an individual married to another, or who has a legal relationship to another that this state accords rights and responsibilities equal to, or substantially equivalent to, those of marriage.

22. “Medical evaluation” means an evaluation and consultation of a physician meeting the requirements of Section 903.

23. “Medical information” means any individually identifiable health information obtained by a health care provider in the course of medical evaluation, consultation, diagnosis, or treatment.

24. “Mental health evaluation” means an evaluation and consultation of a mental health professional meeting the requirements of Section 301.

25. “Parent” means an individual who has established a parent-child relationship under this act or other law.

26. “Parent-child relationship” means the legal relationship between a child and a parent of the child. The term includes the mother-child relationship and the father-child relationship.

27. “Participant” means an individual who provides a biological or genetic component of assisted reproduction, an intended parent, and the spouse of an intended parent or gestational carrier. Gestation is a biological component within the meaning of this definition.

28. “Patient” means an individual using assisted reproductive technology under the direction of a provider. An intended parent is a patient.

29. “Physician” means an individual licensed to practice medicine in all its branches in this jurisdiction.

30. “Posthumous conception” means the transfer of an embryo or gametes with the intent to produce a live birth after a gamete provider has died.

31. “Preservation” or “preserve” means maintaining organ, tissue, or cellular utility, including, but not limited to, the freezing and storing thereof through cryopreservation, for use in assisted conception.

32. “Provider” means an individual (a) licensed to administer health care, and (b) who is qualified under this Act to provide ART services, and (c) has a provider-patient relationship with a participant, including all medical, psychological, or counseling professionals. 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.

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

34. “Retrieval” means the procurement of eggs or sperm from a gamete provider.

35. “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

36. “Time of transfer” means the time at which a gamete or embryo is transferred into the body of a woman with the intent to produce live birth.

37. “Transfer” means the placement of an embryo or gametes into the body of a woman with the intent to achieve pregnancy and live birth.

. . .

ARTICLE 2. INFORMED CONSENT

SECTION 201. INFORMED CONSENT STANDARDS

1. Informed consent must be provided by all participants prior to the commencement of assisted reproduction.

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 embryos without affecting the right to 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 donor's, if any, 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.

(c) A description of the known and potential risks, consequences, and benefits of ART. Such description shall include the inherent risk of embryo loss due to aneuploidy, failure of implantation, or thawing, and the risks associated with the use of hormones and other drugs that may be used, egg retrieval, multiple pregnancies, and selective reduction. The patient shall be informed that there may be foreseen or unforeseen legal consequences and that it is advisable to seek legal counsel.

(d) Description of alternative therapies and treatments, including adoption and natural cycling.

(e) A statement that all existing confidentiality protections apply, and information about what these confidentiality protections are.

(f) A guarantee that a patient has access to all of his/her medical information to the extent the law allows in this jurisdiction. The patient may have to pay a reasonable fee for copies of the record.

(g) Disclosure that intended parents have a right to access a summary of medical and psychological information about donors and gestational carriers as described in this Act.

(h) A statement that release of any participant-identifiable information, including images, shall not occur without the consent of the participant in a record.

(i) A statement that the intended parent(s), not the clinic or 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.

(j) 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, death of one or both of them, or subsequent disagreement over disposition in compliance with the provisions of Section 501 of this Act.

(k) 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 and SART.

(l) A statement of the need for participants to decide whether the embryos or gametes can be used for purposes other than assisted reproduction.

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;
- (c) Include an agreement in a record clarifying, to the extent possible, parental rights of all participants (participants not named are presumed to have no parental rights or duties) if collaborative reproduction is used;
- (d) State that disclosures have been made pursuant to this Act;
- (e) Specify the length of time the consent remains valid; and
- (f) Advise the party signing the informed consent document of the right to receive a copy of the record.

2. Except in an emergency, the record(s) must be signed by the parties before informed consent is valid or the commencement of any assisted reproduction.

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

SECTION 203. DISCLOSURES

1. Disposition of preserved embryos. Prior to each retrieval and each transfer, a provider must disclose to all participants who have not waived that right in a record the following possible dispositions of embryos, together with a statement as to which are allowed under applicable law:

- (a) Storage, including length of time, costs, and location;
- (b) Transfer;
- (c) Donation:
 - (i) To a known individual for transfer;
 - (ii) To an anonymous individual for transfer;
 - (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. Transfer disclosure. Before each 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 created;

(ii) Number viable for transfer;

(iii) Number to be transferred;

(iv) Number preserved;

(v) Quality of each embryo transferred; and

(vi) Quality of each embryo preserved;

(d) For the transfer of preserved embryos:

(i) Number of embryos thawed;

(ii) Number of embryos viable for transfer after thawing; and

(iii) Quality of embryos transferred;

(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 or psychological evaluation or 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 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 side effects;
- (b) Alternative drug therapies and natural cycling;
- (c) Process of drug administration; and
- (d) Whether the drug is approved for this purpose by the Food and Drug Administration (FDA).

6. Disclosure regarding multiple births/retrievals. Where relevant, a provider must disclose prior to retrieval to participants other than donors, in a record, the known risks of multiple births, including the positive and negative factors involved in selective reduction. A provider must disclose prior to retrieval to individuals undergoing egg retrieval the known risks of multiple retrievals.

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

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 in accordance with the requirements set forth elsewhere in this Act.

2. A donor who has given permission for release of identifying health or other information may not revoke such permission after transfer of the donated gametes or of embryos created with the donated gametes.

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 OR EMBRYOS FROM PRESERVED TISSUE OR FROM DECEASED OR INCOMPETENT INDIVIDUALS

1. Gametes or embryos shall not be collected from deceased or incompetent individuals or from preserved tissues unless consent in a record was executed prior to death or incompetency by the individual from whom the gametes or embryos are to be collected or the individual's authorized fiduciary who has express authorization from the principal to so 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 or embryos are collected pursuant to paragraph 2 of this Section, transfer of gametes or of an embryo is expressly prohibited unless approved by a Court. Absence of a record as described in Paragraph 1 shall constitute a presumption of non-consent.

4. Any individual or entity not acting in accordance with this Section may be subject to civil and/or criminal liability as provided in law.

SECTION 206. LOSS OF EMBRYOS OR GAMETES DUE TO NATURAL DISASTER, ACT OF GOD, OR WAR

A storage facility for embryos or gametes is not liable for destruction or loss of embryos due to natural disaster, act of God, or war.

ARTICLE 3. MENTAL HEALTH CONSULTATION/ADDITIONAL COUNSELING

SECTION 301. CONSULTATION AS TO MENTAL HEALTH

1. All participants known to the ART provider must undergo a mental health consultation in accordance with [the most recently published standards of ASRM and SART prior to the ART procedure]. Providers of the consultation must demonstrate contemporaneous knowledge and consideration of the most recently published guidelines of ASRM and SART. The results of this consultation shall not be used to arbitrarily deny any intended parent the right to procreate.

2. During the consultation, the provider must offer additional counseling to each participant. The offer of counseling is mandatory, but the participant's acceptance of additional counseling is voluntary.

3. For purposes of this Article, Mental health professional is an individual who:

(a) Holds a Masters 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 in this jurisdiction to practice in the mental health field; and

(c) Where reasonably possible, has received training in, or has knowledge of, reproductive physiology; the testing, diagnosis, and treatment of infertility; and/or the psychological issues in infertility and collaborative reproduction. If there are questions about inherited or genetic disorders, the counselor must refer the participant to a qualified genetic counselor.

SECTION 302. ADDITIONAL COUNSELING REQUIREMENTS

1. No ART procedure that involves the transfer of donor gametes or embryos to a female intended parent or of gametes or embryos to a gestational carrier shall be initiated or performed until:

(a) All participants made known to the ART provider have been offered mental health counseling following the initial consultation as provided for in Section 301;

(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);

(c) If applicable, a prospective gestational carrier has undergone a mental health evaluation to determine her suitability to participate in collaborative reproduction; and

(d) The intended parents have undergone a mental health evaluation to determine their suitability to participate in collaborative reproduction. This evaluation is not intended to be an evaluation of the intended parent's(s') suitability to parent.

2. Opportunity to receive counseling. It shall be conclusively presumed that a participant has had the 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. Prior to any transfer of gametes or embryos and prior to execution of any collaborative reproduction agreement, an intended parent shall be informed that, upon intended parent's request, the mental health professional's recommendation regarding the assessment of a participant for collaborative reproduction shall be provided by the ART provider.

ARTICLE 4. PRIVACY AND CONFIDENTIALITY

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.

ARTICLE 5. EMBRYO TRANSFER AND DISPOSITION OF EMBRYOS NOT TRANSFERRED

SECTION 501. PARENTAL RIGHTS AND OBLIGATIONS UNDER EMBRYO AGREEMENTS

1. Binding agreements executed prior to embryo creation must be entered into a record by intended parents as to:

- (a) Intended use and disposition of embryos;
- (b) The use and disposition of preserved embryos in the event of divorce of intended parents, if married, illness, incapacity, or death of one or both intended parents, or other change of circumstances such as separation or estrangement; and
- (c) The time at which, and conditions under which, preserved embryos will be deemed abandoned and the policy of the clinic and/or storage facility as to the disposition thereof.

Such agreements may be amended at any time prior to transfer of an embryo or the death of either intended parent.

2. All agreements shall include a permanent address and permanent identifier of the intended parents.

3. Any agreement must be entered in a record and incorporate the following:

- (a) Subject to withdrawal of consent as set forth in paragraphs 3 (c) and (d) hereof, intended parents must agree whether an intended parent may use the embryos in the event of divorce, illness, incapacity, or death of the other intended parent; and
- (b) Clarify which intended parent may control the embryos in the event of divorce, illness, or death; and
- (c) In the event of a subsequent disagreement between intended parents, wherein one intended parent no longer wishes to use stored embryos as previously agreed, after receipt of notice in a record by the other intended parent and by the clinic or storage facility of that individual's intent to avoid conception, an intended parent may not transfer the embryos into the body of any woman with the intent to create a child. No prior agreement to the contrary will be enforceable.
- (d) Any party to an embryo storage or disposition agreement may withdraw his or her consent to the terms of the agreement in a record as set forth in paragraph 3 (c) of this Section.

(e) In the event that a transfer occurs after receipt of notice in a record of that individual's intent to avoid gestation as set forth in paragraph 3(c) of this Section, that intended parent will not be the parent of a resulting child.

(f) 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 may discard, donate, or use the embryos for his/her own parenting purposes. An individual 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.

4. No provider shall transfer or create any embryos following the death of an intended parent unless the necessary consent referred to in 3(f) of this Section is obtained and permanently recorded.

5. In the event that a binding agreement is not executed prior to embryo creation, the intended parents may execute an agreement consistent with this Section that will be enforceable on a prospective basis.

SECTION 502. DONATION OF UNUSED EMBRYOS

Intended parents may choose to donate their unused 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. Donation to known individuals may only be done for the purpose of the recipient attempting to create 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 will require 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 both gamete providers and of the intended parents. After a gamete provider has died, that individual's consent endures and is irrevocable.

SECTION 503. SCREENING OF EMBRYO DONORS

Donors shall be screened prior to such donation in compliance with applicable state and federal law. Permanent records of the donation shall be maintained.

SECTION 504. ABANDONMENT OF EMBRYOS AND DISPOSITION OF ABANDONED EMBRYOS

1. An embryo is deemed to be abandoned only if:

(a) At least five years have elapsed since creation of the embryo unless the participants select another time by agreement as provided in paragraph 1(c) of Section 501; and

(b) A diligent attempt to notify the interested participants, as well any provider(s) who contracted for storage, that the 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 acquisition by the storage facility.

2. Disposition of an embryo deemed to be abandoned under Paragraph 1 must be in accordance with the most recent recorded agreement between participants and the 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 of competent jurisdiction.

3. A storage facility that disposes of 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 embryos, absent criminal intent, gross negligence, or intentional misconduct.

SECTION 505. TRANSPORTATION OF EMBRYOS

1. Transportation of embryos is the responsibility of the individual or individuals requesting the transfer.

2. Unless the 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

Legislative Note: It is not the intent of this act to conflict with or supersede provisions of the Uniform Parentage Act or applicable intestacy provisions of the Uniform Probate Code. Accordingly, any state or territory considering adoption of this Act should review its statutes to determine if those uniform acts have been adopted in that jurisdiction and, if so, to refer to those existing provisions rather than enacting this Article 6.

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 gestational agreement as provided in Article 7.

SECTION 602. PARENTAL STATUS OF DONOR.

A donor is not a parent of a child conceived by means of assisted reproduction.

SECTION 603. PARENTAGE OF CHILD OF ASSISTED REPRODUCTION.

An individual who provides gametes for, or consents to, assisted reproduction by a woman as provided in Section 604 with the intent to be a parent of her child is a parent of the resulting child.

SECTION 604. CONSENT TO ASSISTED REPRODUCTION.

1. Consent by an individual who intends to be a parent of a child born by assisted reproduction must be in a signed record. . This requirement does not apply to a donor.
2. Failure of an individual to sign a consent required by paragraph 1, before or after birth of the child, does not preclude a finding of parentage if the woman and the intended parent, during the first two years of the child's life, resided together in the same household with the child and openly held out the child as their own.

SECTION 605. LIMITATION ON LEGAL SPOUSE'S DISPUTE OF PARENTAGE

1. Except as otherwise provided in subsection 2, the legal spouse of a woman who gives birth to a child by means of assisted reproduction may not challenge the parentage of the child unless:
 - (a) Within two years after learning of the birth of the child a proceeding is commenced to adjudicate parentage; and
 - (b) The court finds that the legal spouse did not consent to assisted reproduction, before or after birth of the child.
2. A proceeding to adjudicate parentage may be maintained at any time if the court determines that:
 - (a) The legal spouse did not provide gametes for, or before or after the birth of the child consent to, assisted reproduction by the individual who gives birth ;
 - (b) The legal spouse and the parent of the child have not cohabited since the probable time of assisted reproduction; and
 - (c) The legal spouse never openly held out the child as his or her own.
3. The limitation provided in this Section applies to a marriage declared invalid after assisted reproduction.

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

1. If a marriage is dissolved before transfer of eggs, sperm, or embryos, 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 at any time before placement of eggs, sperm, or embryos. 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 placement of eggs, sperm, or embryos, 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. GESTATIONAL AGREEMENT

[Legislative Note: It is not the intent of this act to conflict with or supersede provisions of the Uniform Parentage Act or applicable intestacy provisions of the Uniform Probate Code. Accordingly, any state or territory considering adoption of this model act should carefully review its statutes to determine if those uniform acts have been adopted in that jurisdiction and, if so, refer to those existing provisions rather than enacting either alternative of this Article 7. Since the gestational agreement provisions of the Uniform Parentage Act are bracketed and, therefore, optional, an alternative procedure to determine parentage in a gestational surrogacy arrangement is offered that does not require a judicial proceeding if, and only if, the parties comply with all of the other procedural protections of the statutory alternative. The judicial preauthorization model is offered as Alternative A, and the administrative model is offered as Alternative B.]

[ALTERNATIVE A:

SECTION 701. GESTATIONAL AGREEMENT AUTHORIZED

1. A prospective gestational carrier, her legal spouse if she is married, a donor or the donors, and the intended parent(s) may enter into a agreement in a record providing that:
 - (a) The prospective gestational carrier agrees to pregnancy by means of assisted reproduction;
 - (b) The prospective gestational carrier, her legal spouse if she is married, and the donors relinquish all rights and duties as the parents of a child conceived through assisted reproduction; and
 - (c) The intended parents become the parents of the child.
2. The intended parents must be parties to the gestational agreement.
3. A gestational agreement is enforceable only if validated as provided in Section 703.
4. A gestational agreement does not apply to the birth of a child conceived by means of sexual intercourse.
5. A gestational agreement may provide for payment of consideration under Article 8 of this Act.
6. A gestational agreement may not limit the right of the gestational carrier to make decisions to safeguard her health or that of the embryo(s) or fetus.

SECTION 702. REQUIREMENTS OF PETITION

1. The intended parents and the prospective gestational carrier may commence a proceeding in the [appropriate court] to validate a gestational agreement.

2. A proceeding to validate a gestational agreement may not be maintained unless:
 - (a) The carrier or the intended parents have been residents of this State for at least 90 days;
 - (b) The prospective gestational carrier's legal spouse, if she is married, is joined in the proceeding; and
 - (c) A copy of the gestational agreement is attached to the petition.

SECTION 703. HEARING TO VALIDATE GESTATIONAL AGREEMENT

1. If the requirements of paragraph 2 are satisfied, a court may issue an order validating the gestational agreement and declaring that the intended parents will be the parents of a child born during the term of the agreement.
2. The court may issue an order under paragraph 1 only on finding that:
 - (a) The residence requirements of Section 702 have been satisfied and the parties have submitted to the jurisdiction of the court under the jurisdictional standards of this Act;
 - (b) Unless waived by the court, the relevant child-welfare agency has made a home study of the intended parents and the intended parents meet the standards of suitability applicable to adoptive parents;
 - (c) All parties have voluntarily entered into the agreement and understand its terms;
 - (d) Adequate provision has been made for all reasonable health-care expense associated with the gestational agreement until the birth of the child, including responsibility for those expenses if the agreement is terminated; and
 - (e) The consideration, if any, paid to the prospective gestational carrier is reasonable.

SECTION 704. INSPECTION OF RECORDS

The proceedings, records, and identities of the individual parties to a gestational agreement under this article are subject to inspection under the standards of confidentiality applicable to adoptions as provided under other law of this State.

SECTION 705. EXCLUSIVE, CONTINUING JURISDICTION

Subject to the jurisdictional standards of Section 201 of the Uniform Child Custody Jurisdiction and Enforcement Act, the court conducting a proceeding under this article has exclusive, continuing jurisdiction of all matters arising out of the gestational

agreement until a child born to the gestational carrier during the period governed by the agreement attains the age of 180 days.

SECTION 706. TERMINATION OF GESTATIONAL AGREEMENT

1. After issuance of an order under this article, but before the prospective gestational carrier becomes pregnant by means of assisted reproduction, the prospective gestational carrier, her legal spouse, or either of the intended parents may terminate the gestational agreement by giving notice of termination in a record to all other parties.
2. The court for good cause shown may terminate the gestational agreement.
3. An individual who terminates a gestational agreement shall file notice of the termination with the court. On receipt of the notice, the court shall vacate the order issued under this article. An individual who does not notify the court of the termination of the agreement is subject to appropriate sanctions.
4. Neither a prospective gestational carrier nor her legal spouse, if any, is liable to the intended parents for terminating a gestational agreement pursuant to this Section.

SECTION 707. PARENTAGE UNDER VALIDATED GESTATIONAL AGREEMENT

1. Upon birth of a child to a gestational carrier, the intended parents shall file notice with the court that a child has been born to the gestational carrier within 300 days after assisted reproduction. Thereupon, the court shall issue an order:
 - (a) Confirming that the intended parents are the parents of the child;
 - (b) If necessary, ordering that the child be surrendered to the intended parents; and
 - (c) Directing the agency maintaining birth records to issue a birth certificate naming the intended parents as parents of the child.
2. If the parentage of a child born to a gestational carrier is alleged not to be the result of assisted reproduction, the court shall order genetic testing to determine the parentage of the child.
3. If the intended parents fail to file notice required under paragraph 1, the gestational carrier or the appropriate State agency may file notice with the court that a child has been born to the gestational carrier within 300 days after assisted reproduction. Upon proof of a court order issued pursuant to Section 703 validating the gestational agreement, the court shall order the intended parents are the parents of the child and are financially responsible for the child.

SECTION 708. GESTATIONAL AGREEMENT: EFFECT OF SUBSEQUENT MARRIAGE

1. After the issuance of an order under this article, subsequent marriage of the gestational carrier does not affect the validity of a gestational agreement, her legal spouse's consent to the agreement is not required, and her legal spouse is not a presumed father of the resulting child.

SECTION 709. EFFECT OF NONVALIDATED GESTATIONAL AGREEMENT

1. A gestational agreement, whether in a record or not, that is not judicially validated is not enforceable.
2. If a birth results under a gestational agreement that is not judicially validated as provided in this Section 703, the parent-child relationship is determined as provided under other law.
3. Individuals who are parties to a nonvalidated gestational agreement as intended parents may be held liable for support of the resulting child under other law.

END ALTERNATIVE A]

[ALTERNATIVE B:

SECTION 701. RIGHTS OF PARENTAGE

1. Except as provided in this Act, the woman who gives birth to a child is presumed to be the mother of that child for purposes of State law.
2. In the case of a gestational carrier arrangement satisfying the requirements set forth in paragraph 4 of this Section:
 - (a) The intended parents shall be the parents of the child for purposes of State law immediately upon the birth of the child;
 - (c) The child shall be considered the child of the intended parent or parents for purposes of State law immediately upon the birth of the child;
 - (d) Parental rights shall vest in the intended parent or parents immediately upon the birth of the child;
 - (e) Sole custody of the child shall rest with the intended parent or parents immediately upon the birth of the child; and
 - (f) Neither the gestational carrier nor her 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 gestational carrier arrangement meeting the requirements set forth in subsection 4 of this Section, in the event of a laboratory error in which the resulting child is not genetically related to either of the intended parents, the intended parents will be the parents of the child for purposes of State law unless otherwise determined by a court of competent jurisdiction in an action which can only be brought by one or more of the genetic parents within sixty (60) days of the date of the child's birth.

4. The parties to a gestational carrier arrangement shall assume the rights and obligations of paragraphs 2 and 3 of this Section if:

(a) The gestational carrier satisfies the eligibility requirements set forth in paragraph 1 of Section 702;

(b) The intended parent or parents satisfy the eligibility requirements set forth in paragraph 2 of Section 702; and

(c) The gestational carrier arrangement occurs pursuant to a gestational agreement meeting the requirements set forth in Section 703.

SECTION 702. ELIGIBILITY

1. A gestational carrier shall be deemed to have satisfied the requirements of this Act if she has met the following requirements at the time the gestational agreement is executed:

(a) She is at least 21 years of age;

(b) She has given birth to at least one child;

(c) She has completed a medical evaluation relating to the anticipated pregnancy;

(d) She has completed a mental health evaluation relating to the anticipated gestational carrier arrangement;

(e) She has undergone legal consultation with independent legal counsel regarding the terms of the gestational agreement and the potential legal consequences of the gestational carrier arrangement; and

(f) She has, or obtains prior to the embryo transfer, a health insurance policy that covers major medical treatments and hospitalization and the health insurance policy has a term that extends throughout the duration of the expected pregnancy and for 8 weeks after the birth of the child; provided, however, that the policy may be procured by the intended parents on behalf of the gestational carrier pursuant to the gestational agreement.

2. The intended parent or parents shall be deemed to have satisfied the requirements of this Act if he, she, or they have met the following requirements at the time the gestational agreement is executed:

- (a) He, she, or they contribute at least one of the gametes that will ultimately result in an embryo that the gestational carrier will attempt to carry to term;
- (b) He, she, or they have a medical need for the gestational carrier arrangement as evidenced by a qualified physician's affidavit attached to the gestational agreement;
- (c) He, she, or they have completed a mental health evaluation relating to the anticipated gestational carrier arrangement; and
- (d) He, she, or they have undergone legal consultation with independent legal counsel regarding the terms of the gestational agreement and the potential legal consequences of the gestational carrier arrangement.

SECTION 703. REQUIREMENTS FOR A GESTATIONAL AGREEMENT.

1. A gestational agreement is enforceable only if:
 - (a) It meets the contractual requirements set forth in paragraph 2 of this Section; and
 - (b) It contains at a minimum each of the terms set forth in paragraph 3 of this Section.
2. A gestational agreement shall meet the following requirements:
 - (a) It shall be in writing;
 - (b) It shall be executed prior to the commencement of any medical procedures in furtherance of the gestational carrier arrangement (other than medical or mental health evaluations necessary to determine eligibility of the parties pursuant to Section 702 of this Act) :
 - (i) By a gestational carrier meeting the eligibility requirements of paragraph 1 of Section 702 of this Act and, if married, the gestational carrier's legal spouse; and
 - (ii) By the intended parent or parents meeting the eligibility requirements of paragraph 2 of Section 702 of this Act. In the event an intended parent is married, both wife and her legal spouse must execute the gestational agreement;
 - (c) Each of the gestational carrier and the intended parent or parents shall have been represented by separate, independent counsel in all matters concerning the gestational carrier arrangement and the gestational agreement;
 - (d) Each of the gestational carrier and the intended parent or parents shall have signed a written acknowledgment that he or she received information about the

legal, financial, and contractual rights, expectations, penalties, and obligations of the gestational agreement;

(e) If the gestational agreement provides for the payment of compensation to the gestational carrier, the compensation shall have been placed in escrow with an independent escrow agent prior to the gestational carrier's commencement of any medical procedure (other than medical or mental health evaluations necessary to determine the gestational carrier's eligibility pursuant to paragraph 1 of Section 702 of this Act); and

(f) It shall be witnessed by two (2) disinterested competent adults.

3. A gestational agreement shall provide for:

(a) The express written agreement of the gestational carrier to:

(i) Undergo embryo or gamete transfer and attempt to carry and give birth to the child; and

(ii) Surrender custody of all resulting children to the intended parent or parents immediately upon the birth;

(b) If the gestational carrier is married, the express agreement of her legal spouse to:

(i) Undertake the obligations imposed on the gestational carrier pursuant to the terms of the gestational agreement; and

(ii) Surrender custody of all resulting children to the intended parent or parents immediately upon the birth;

(c) The right of the gestational carrier to utilize the services of a physician of her choosing, after consultation with the intended parents, to provide her care during the pregnancy; and

(d) The express written agreement of the intended parent or parents to:

(i) Accept custody of all resulting children immediately upon birth regardless of number, gender, or mental or physical condition; and

(ii) Assume sole responsibility for the support of the child immediately upon his or her birth.

4. A gestational agreement is enforceable even though it contains one or more of the following provisions:

(a) The gestational carrier's agreement to undergo all medical exams, treatments, and fetal monitoring procedures that the physician recommends for the success of the pregnancy;

(b) The gestational carrier's agreement to abstain from any activities that the intended parent or parents or the physician reasonably believes to be harmful to the pregnancy and future health of the child, including, without limitation, smoking, drinking alcohol, using non-prescribed drugs, using prescription drugs not authorized by a physician aware of the gestational carrier's pregnancy, exposure to radiation, or any other activities proscribed by a health care provider;

(c) The agreement of the intended parent or parents to pay the gestational carrier reasonable compensation; and

(d) The agreement of the intended parent or parents to pay for or reimburse the gestational carrier for reasonable expenses (including, without limitation, medical, legal, or other professional expenses) related to the gestational carrier arrangement and the gestational agreement.

SECTION 704. DUTY TO SUPPORT

1. Any individual who is considered to be the parent of the child pursuant to Section 701 of this Act shall be obligated to support the child.
2. The breach of the gestational agreement by the intended parent or parents shall not relieve such intended parent or parents of the support obligations imposed by this Act.
3. A gamete donor may be liable for child support only if he or she fails to enter into a legal agreement in which the donor relinquishes rights to any gametes, resulting embryos, or children and the intended parent or parents fail to enter into an agreement in which the intended parent or parents agree to assume all rights and responsibilities for any resulting child.

SECTION 705. ESTABLISHMENT OF THE PARENT-CHILD RELATIONSHIP

1. For purposes of the State's relevant parentage act, the parent-child relationship that arises immediately upon the birth of the child pursuant to Section 701 is established, if, prior to or within 24 hours of the birth of a child born through a gestational carrier arrangement, the attorneys representing both the gestational carrier and the intended parent or parents certify that the parties entered into the gestational agreement intended to satisfy the requirements of Section 703 of this Act with respect to the child.
2. The attorneys' certifications required by paragraph 1 of this Section shall be filed on forms prescribed by the relevant State regulatory agency and in a manner consistent with the requirements of the State's relevant parentage act, if any.

3. The attorney certifications required by paragraph 1 of this Section shall be effective for all purposes hereunder if completed prior to or within twenty-four (24) hours after the child's birth.

4. Upon compliance with the certification provision of this Section, all hospital representatives and/or employees and the State's relevant regulatory agency shall complete all birth records and the original birth certificate of the child to reflect the intended parent or parents, and only the intended parent or parents, as the child's parent(s) thereon.

SECTION 706. EFFECT OF GESTATIONAL CARRIER'S SUBSEQUENT MARRIAGE

Subsequent marriage of the gestational carrier after her execution of a gestational agreement does not affect the validity of the gestational agreement, her legal spouse's consent to the gestational agreement is not required, and her legal spouse is not a presumed parent of the resulting child.

SECTION 707. IMMUNITIES

Except as provided in this Act, no person shall be civilly or criminally liable 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 708. NONCOMPLIANCE

Noncompliance occurs when the gestational carrier, her spouse, or the intended parent or parents breach a provision of the gestational agreement or any party to or agreement for a surrogacy arrangement fails to meet any of the requirements of this Act.

SECTION 709. EFFECT OF NONCOMPLIANCE

1. In the event of Noncompliance as defined in Section 707, a 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.

2. There shall be no specific performance remedy available for a breach by the gestational carrier of a gestational agreement term that requires her to be impregnated.

SECTION 710. DAMAGES

1. Except as expressly provided in the gestational agreement, the intended parent or parents shall be entitled to all remedies available at law or equity.

2. Except as expressly provided in the gestational agreement, the gestational carrier shall be entitled to all remedies available at law or equity.

SECTION 711. RULEMAKING

The relevant State regulatory agency may adopt rules pertaining to the required medical and mental health evaluations for a gestational agreement. Until the relevant State regulatory agency adopts such rules, medical and mental health evaluations and procedures shall be conducted in accordance with the recommended guidelines published by the ASRM, SART, and the American College of Obstetricians and Gynecologists (ACOG). The rules may adopt these guidelines or others by reference.

SECTION 712. IRREVOCABILITY

No action to invalidate a gestational carrier arrangement meeting the requirements of paragraph 4 of Section 701 of this Act or to challenge the rights of parentage established pursuant to Section 701 of this Act and the relevant State parentage act provisions shall be commenced after 12 months from the date of birth of the child.

END ALTERNATIVE B]

ARTICLE 8. PAYMENT TO DONORS AND GESTATIONAL CARRIERS

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 the donor has entered into valid agreement in a record to be a donor may not be reimbursed, except as provided for in paragraph 3 hereof.
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 consideration, if any, paid to a donor or prospective gestational carrier must be reasonable and negotiated in good faith between the parties.

2. Compensation may not be conditioned upon the 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. For the purposes of health insurance coverage, infertility means:

(a) Resulting from a disease or condition that causes abnormal function of the reproductive system, the inability to:

(i) Conceive after attempts at conception by unprotected sexual intercourse have been made for at least one year; or

(ii) Sustain a pregnancy to live birth; or

(b) The presence of another condition recognized by accepted medical standards as a cause of the inability to achieve or sustain a pregnancy to live birth; or

(c) The desire to achieve pregnancy by means other than sexual intercourse. Insurance coverage provided for (a) and (b) above may not be denied on the basis of this subparagraph.

2. 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, application, or 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;

(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

ART providers, ART clinics, 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 participate 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 shall participate in the College of American Pathologists and the American College of Medical Genetics genetic proficiency testing programs.

SECTION 1002. DONOR AND COLLABORATIVE REPRODUCTION REGISTRIES

1. Donor and collaborative reproduction registries (or equivalent) created for the purpose of maintaining contact, medical, and psychosocial information about donors, gestational carriers, 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, except as may be otherwise required or permitted by federal or state law.

SECTION 1003. HEALTH INFORMATION MANAGEMENT

1. The provider shall:

- (a) Maintain a permanent address for contact by patients, resulting children, and participants;
 - (b) 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) 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) Maintain an accurate record of the disposition of all gametes and embryos.
2. The program shall maintain all records in compliance with State and Federal law.
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 signed pursuant to Articles 2 and 4 of this Act;
- (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 carriers in compliance with the laws and regulations of or applying to appropriate governmental regulatory authorities; and
2. Conduct medical screening of gamete and embryo donors for genetic disorders. The extent of such screening shall be in conformity with guidelines established by the ASRM and SART. 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, a participant whose ART 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 attorneys fees, and the costs of litigation.
3. Failure to account for all embryos, misuse of embryos, theft of embryos, or unauthorized disposition of embryos shall subject a provider or ART storage facility to criminal and civil penalties, including punitive damages, and reasonable legal fees to the prevailing party.

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.
2. The presumption in paragraph 1 is rebuttable only upon a showing that an issue relating to a standard of care not covered in the practice and ethical guidelines or

regulatory or statutory standards, as described in Paragraph 1, exists, and upon a finding that there has been a breach of the standard of care on that issue.

3. No cause of action initiated more than six years after the birth of a child from ART, or more than two years after injury resulting from ART could reasonably have been detected, whichever is greater, shall be valid.

SECTION 1202. SEVERABILITY

The invalidation of any part of this legislation by a court of competent jurisdiction shall not result in the invalidation of any other part.