By Senator Grall

29-00895C-26 20261044__

A bill to be entitled

An act relating to informed consent for assisted reproductive technology; amending s. 742.17, F.S.; revising requirements for certain written disposition agreements required between a commissioning couple and a treating physician; creating s. 742.175, F.S.; defining terms; prohibiting health care providers from performing in vitro fertilization without first obtaining informed consent from the commissioning couple; requiring that such informed consent be obtained each time a new in vitro fertilization cycle is undertaken; requiring health care providers to provide the patient certain information; providing construction; specifying requirements for the informed consent form; requiring health care providers to enter into a written disposition agreement with patients to track specified elections; specifying requirements for such agreements; prohibiting health care providers from discarding embryos for nonpayment unless certain conditions are met; providing construction; requiring health care providers to disclose their policies; requiring health care providers to provide certain disclosures within a specified timeframe; providing an exception; requiring health care providers to provide informed consent in the patients' primary language or with a qualified interpreter; requiring that the informed consent form state whether an interpreter was used; requiring health care providers to offer patients the opportunity to ask questions and withdraw

consent without penalty at any time before an embryo transfer; requiring health care providers to retain certain records for a specified timeframe; requiring health care providers to provide patients a copy of their records upon request within a specified timeframe; providing for disciplinary action; providing construction; providing severability; amending s. 456.072, F.S.; conforming a provision to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 742.17, Florida Statutes, is amended to read:

742.17 Disposition of eggs, sperm, or preembryos; rights of inheritance.—A commissioning couple and the treating physician shall enter into a written agreement that provides for the future use of the embryos by the commissioning couple, continued storage with payment, embryo transfer to another couple, permission for or prohibition of research donation, selections for contingencies per s. 742.175(4)(b), and the disposition of the commissioning couple's eggs, sperm, and preembryos in the event of a divorce, the death of a spouse, or any other unforeseen circumstance.

(1) Absent a written agreement, any remaining eggs or sperm shall remain under the control of the party that provides the eggs or sperm.

(2) Absent a written agreement, decisionmaking authority regarding the disposition of preembryos shall reside jointly

with the commissioning couple.

(3) Absent a written agreement, in the case of the death of one member of the commissioning couple, any eggs, sperm, or preembryos shall remain under the control of the surviving member of the commissioning couple.

(4) A child conceived from the eggs or sperm of a person or persons who died before the transfer of their eggs, sperm, or preembryos to a woman's body shall not be eligible for a claim against the decedent's estate unless the child has been provided for by the decedent's will.

Section 2. Section 742.175, Florida Statutes, is created to read:

742.175 Assisted reproductive technology; informed consent; required disclosures; embryo disposition.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Assisted reproductive technology" has the same meaning as provided in s. 742.13 and includes in vitro fertilization, intracytoplasmic sperm injection, embryo culture, cryopreservation, and embryo transfer.

(b) "Commissioning couple" has the same meaning as provided in s. 742.13.

(c) "Cryopreservation" means, with respect to embryos, freezing the embryos in an undisturbed environment for the purpose of saving them for future procreative use.

(d) "Cycle" means a single procedure of in vitro fertilization, zygote intrafallopian transfer, or gamete intrafallopian transfer.

(e) "Embryo" means the product of fertilization of an egg by a sperm until the appearance of the embryonic axis.

(f) "Health care provider" means a health care practitioner as defined in s. 456.001 who is authorized to provide assisted reproductive technology services under his or her applicable scope of practice.

(g) "Independently reported success rate data" means public, audited data on assisted reproductive technology outcomes, including national and clinic-level reports, maintained by the United States Centers for Disease Control and Prevention's National ART Surveillance System and the Society for Assisted Reproductive Technology.

(h) "Informed consent" means a voluntary, written, and signed authorization, executed after receipt of the disclosures required by this section provided in plain language understandable to a layperson.

(i) "In vitro fertilization" means a form of assisted reproductive technology in which an egg retrieved from a woman's ovaries is fertilized with sperm in a culture medium in a laboratory and then transferred to the uterus for the purpose of producing a pregnancy.

(j) "Selective reduction" means an abortion as defined in s. 390.011 which reduces the number of fetuses in a multifetal pregnancy by one or more to lower maternal and neonatal risks and results in the intentional death of one or more fetuses with the goal of continuing the pregnancy with fewer fetuses.

(k) "Single-embryo transfer" means transferring one embryo in a given transfer procedure to reduce the risk of multiple gestation, consistent with professional guidelines that limit the number of embryos transferred by age and prognosis.

(l) "Transfer" means the process by which a health care

provider places a fresh or frozen embryo within the uterus, fallopian tubes, or other part of a patient's body for the purpose of initiating a pregnancy.

(2) INFORMED CONSENT REQUIRED.—

(a) A health care provider may not perform in vitro fertilization, including ovarian stimulation, egg retrieval, fertilization, embryo biopsy, embryo storage, and embryo transfer, until each adult patient and, if applicable, both members of the commissioning couple have executed the informed consent form required under subsection (3).

(b) A health care provider must obtain informed consent each time a new cycle is undertaken and must provide updated information to the patient with the latest statistics and findings concerning the patient's status with each new cycle.

(c) This section supplements ss. 742.11-742.17 and does not diminish requirements for written agreements regarding gamete and embryo disposition under s. 742.17.

(d) This section does not prohibit a physician from providing any additional information the physician deems material to the patient's informed decision to undergo in vitro fertilization.

(3) INFORMED CONSENT FORM.—

(a) The informed consent form must include all of the following:

1. A description of the in vitro fertilization procedure.

2. Information about embryo conception and transfer, including the patient's right to determine the number of embryos or eggs to conceive and transfer, and the most recent scientific information on the number of embryos needed to be transferred to

achieve a successful pregnancy.

3. A statement that the patient retains the right to withhold or withdraw consent at any time before transfer of gametes or embryos without affecting the patient's right to future care or treatment.

4. A description of the facility's practice regarding selecting embryos that are viable to transfer and the outcome for embryos that are deemed not viable for transfer, including whether those embryos will be destroyed or used for training or research.

5. A description of the facility's practice regarding cryopreservation of embryos and the associated costs.

6. The effect of the following on treatment, embryos, and the validity of informed consent: the health care provider's practice closing; divorce; separation; failure to pay storage fees for nontransferred embryos; failure to pay treatment fees; inability to agree on the fate of embryos; the death of a patient or others; withdrawal of consent for transfer after fertilization but before cryopreservation; incapacity; unavailability of agreed-upon disposition of embryos; or loss of contact with the facility.

(b) The informed consent form must also disclose all of the following:

1. Medical risks to the person undergoing treatment, including all of the following:

a. Medication and ovarian response risks, including ovarian hyperstimulation syndrome. The form must describe signs and symptoms of and methods for preventing ovarian hyperstimulation syndrome, including the use of individualized ovarian

stimulation, gonadotropin-releasing hormone agonist triggers, and freezing all embryos after a cycle to transfer in a separate, subsequent cycle. The form must also state that moderate-to-severe ovarian hyperstimulation syndrome occurs in approximately 1 to 5 percent of cycles, varying by individual risk and declining with modern prevention methods.

b. Procedure and anesthesia risks from egg retrieval, including pain, bleeding, infection, injury to adjacent structures, and rare serious complications.

c. Pregnancy-related risks, including ectopic pregnancy, miscarriage, hypertensive disorders, and diabetes, noting that ectopic pregnancy after in vitro fertilization has been reported in the range of approximately 1.4 to 3.2 percent of in vitro fertilization pregnancies, with patient-specific variation.

2. Medical risks to children conceived through in vitro fertilization, specifically that:

a. Multiple gestation carries increased risks of prematurity, low birth weight, and neonatal morbidity compared with singletons; and

b. Most children conceived through in vitro fertilization are healthy, but some adverse outcomes, including premature births or low birth weights among singleton pregnancies, have been observed in surveillance reports, and that historic multiple-embryo transfer practices contributed to higher multiple-birth rates.

3. Risks of multiple gestation and selective reduction. The disclosure must:

a. Describe maternal and neonatal complications associated with multiple gestation and explain that preventing multiple

gestation is the safest strategy.

b. Define selective reduction as provided in this section and include the following statement: "If two or more embryos implant, your physician may discuss an option that entails intentionally ending the life of one or more fetuses to reduce the total number of fetuses. You may accept or decline this option."

c. Specify that, in accordance with chapter 390, any selective reduction must be performed before the gestational age of the fetus progresses beyond 6 weeks, unless an exception under s. 390.0111(1) applies.

d. State that single-embryo transfer is an evidence-based strategy to reduce multiple gestation and that professional guidelines limit the number of embryos to transfer by age and prognosis.

e. Identify practices available to minimize embryo loss or destruction. The disclosure must enumerate options and allow patient elections that include all of the following:

(I) Limiting fertilization to the number intended for transfer in current and planned cycles.

(II) Singe-embryo transfers where clinically reasonable, avoiding embryo discard based solely on nonmedical traits.

(III) Embryo cryopreservation and an embryo disposition plan that prioritizes future transfer to the commissioning couple or embryo transfer to another couple. Cryopreserved embryos may be used for research or discarded only if expressly authorized by the patients.

(IV) Mild or natural-cycle stimulation protocols when clinically feasible.

(V) Preimplantation genetic testing limitations, including possible no-result or mosaic findings, and the disclosure that results are not infallible and do not require embryo discard.

4. Financial obligations and costs, including all of the following:

a. A good faith itemized estimate of total cycle costs, including professional and laboratory fees; anesthesia; medications; preimplantation genetic testing, if elected; embryo storage; and anticipated additional procedures.

b. A clear statement that ongoing storage fees will be assessed for cryopreserved embryos and that nonpayment will be handled only as set forth in the patient's embryo disposition agreement under subsection (4) and s. 742.17.

5. The health care provider's transfer policy. If the disclosure does not state the health care provider's transfer policy, the default transfer policy is to perform single-embryo transfers when clinically reasonable.

6. Alternatives to in vitro fertilization. The disclosure must include a description of reasonable alternatives, which may include, but need not be limited to, timed intercourse, lifestyle and medical optimization, natural procreative technology-informed diagnostics, ovulation induction, intrauterine insemination, use of donor gametes, adoption, expectant management, and counseling.

7. Success rates and limits. The disclosure must include all of the following:

a. Required national benchmarks, including present age-stratified independently reported success rate data from the most recent finalized Society for Assisted Reproductive

Technology National Summary Report and any companion first-transfer and subsequent-transfer tables provided for that year.

b. Independent sources patients can check, including the URLs in print and electronically for:

(I) The United States Centers for Disease Control and Prevention National ART Surveillance System's success rates for national and clinic-level data and the Centers for Disease Control and Prevention's guidance on interpreting cumulative success; and

(II) The Society for Assisted Reproductive Technology's Clinic Summary Report, including national and clinic-level data for the latest finalized year.

c. Clinic-specific context, explaining that the data from the United States Centers for Disease Control and Prevention and the Society for Assisted Reproductive Technology is audited, standardized, logged, and finalized after the reporting year, and that individual prognosis varies by age, diagnosis, and treatment plan.

d. A statement that Florida public policy favors singleton birth when medically safe and that health care providers should discuss single-embryo transfer options to reduce the chance of twins or higher-order multiples.

(c) The informed consent form must include initial lines or checkboxes for each of the following patient elections, which the health care provider shall honor unless such elections are unsafe for the patient or unlawful:

...(Initial here)... Embryo creation limit. We authorize insemination or intracytoplasmic sperm

injection of no more than ...(insert desired number)... eggs per cycle.

...(Initial here)... Embryo transfer. We authorize the transfer of ...(insert desired number)... embryos per cycle.

...(Initial here)... Selective reduction preference. Circle one: We decline/may consider selective reduction if recommended. Health care provider policy: ...(insert health care provider's policy on selective reduction, specifying that all selective reduction procedures must be performed in accordance with chapter 390, Florida Statutes)....

...(Initial here)... Preimplantation genetic testing election. Circle one: decline all testing/preimplantation genetic testing for an aneuploidy (PGT-A)/preimplantation genetic testing for a specific condition (PGT-M) (condition: ...(insert condition)...). We understand preimplantation genetic testing is not infallible and does not require embryo discard.

...(Initial here)... Financial responsibility. We understand and accept responsibility for storage fees until a disposition permitted above occurs.

(4) EMBRYO DISPOSITION; CONTINGENCIES.—

(a) A health care provider shall enter into a disposition agreement pursuant to s. 742.17 which tracks the patients' elections under subsection (3).

(b) The agreement must specify the patients' choices upon death or incapacity of one or both patients; divorce or separation; prolonged loss of contact; and nonpayment after a grace period. Options must include continued storage, transfer to the patient or a gestational carrier, or embryo transfer to another couple. Options for research donation or discarding embryos must be expressly selected by the patients in order to occur.

(c) A health care provider may not discard embryos for nonpayment unless all of the following conditions are met:

1. The agreement expressly authorizes that outcome.

2. The health care provider has provided at least two written notices to the patients' last known addresses and a 90-day grace period has passed.

3. Such action complies with all other applicable laws.

(d) This section does not require a health care provider to offer services he or she does not provide; however, the health care provider shall disclose his or her policies.

(5) FORM, TIMING, AND LANGUAGE ACCESS.—

(a) A health care provider shall provide the disclosures required by subsection (3) at least 48 hours before the first injectable medication, unless a shorter interval is medically necessary and the patient affirmatively waives the time interval in writing.

(b) A health care provider shall provide the informed consent form in the patients' primary language or with a

qualified interpreter, and the informed consent form must state whether an interpreter was used.

(c) A health care provider shall offer patients the opportunity to ask questions and to withdraw consent without penalty at any time before embryo transfer.

(d) Electronic signatures are permitted if compliant with state law.

(6) RECORDKEEPING.—

(a) A health care provider shall retain executed informed consent forms, disposition agreements, and any subsequent modifications for at least 7 years after the final embryo is transferred, adopted, or otherwise lawfully disposed of, or for the period required by other applicable law, whichever is longer.

(b) Upon written request, a health care provider shall provide a patient a copy of his or her records without charge within 10 business days after receipt of the written request.

(7) ENFORCEMENT.—Failure to obtain informed consent as required by this section constitutes grounds for disciplinary action under s. 456.072.

(8) CONSTRUCTION.—

(a) This section does not alter parentage presumptions under s. 742.11 or donor provisions under s. 742.14 or the written agreement requirements of s. 742.17.

(b) This section does not mandate selective reduction or embryo destruction, and patients may decline such procedures.

(c) The provisions of this section relating to selective reduction operate consistent with, and do not supplant, chapter 390. The limitations on abortions specified in s. 390.0111 apply

to selective reduction procedures referenced under this section. Chapter 390 prevails in the event of any conflict with this section.

(d) This section must be construed to permit patient elections that minimize embryo loss consistent with medical safety and applicable laws.

(9) SEVERABILITY.—If any provision of this section or its application is held invalid, the invalidity does not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

Section 3. Paragraph (uu) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(uu) Violating any provision of s. 742.175.

Section 4. This act shall take effect July 1, 2026.