Center for Reproductive Medicine • Advanced Reproductive Technologies
www.ivfminnesota.com

DIRECTION FOR DISPOSITION OF FROZEN SPERM

Patient to Complete Below

Print name

Date of Birth (mm/dd/yyyy) | XXX-XX- Last 4 digits of SSN

Signature

Date

Daytime Phone Number

(Check the box that applies)

☐ Discard

I, the undersigned, having previously consented to cryopreservation and/or storage of sperm at the CRM Andrology Laboratory, now request that the surplus cryopreserved sperm be discarded.
I understand that by choosing to discard the sperm; no offspring will result. I freely, voluntarily, and willingly direct and authorize Advanced Reproductive Technologies and the Center for Reproductive Medicine, (collectively, ART/CRM) to discard all of the cryopreserved sperm and release ART/CRM and their board members, physicians, employees and representatives and all their agents from all claims of any nature arising from or related to the discarding of the sperm.

☐ Transfer

Transport the frozen sperm to the facility shown below. I understand that ART/CRM is not responsible for any damage to the frozen sperm that may occur during or after transport, and I release it from any liability for the same.

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Please sign in our presence or have notarized

On this ___day of _____, 20_____before me, personally appeared_____, known to me to be the person described in and who executed the foregoing instrument, and severally acknowledged that they executed the same.

_____
Notary Public (if not signed in our presence)

State of _____ (Notary stamp here)

County of_____

My commission expires:_____

Laboratory Witness (if applicable): _____ _____
Print Name Sign

Driver's License # patient: _____

Date: _____ Pt ID: _____