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

FROZEN SPERM INCOMING TRANSFER CONSENT

I, the undersigned, acknowledge that I am requesting the transfer of my sperm from _____ to the Andrology Laboratory.

With this request, I understand that there is a risk that the sperm may be damaged or destroyed during transportation from the above-mentioned facility to the Andrology Laboratory. I accept this risk and hereby release The Center for Reproductive Medicine (CRM)/Assisted Reproductive Technologies (ART) and its board members, physicians, representatives, employees and agents from any liability associated with the possible damage/destruction of the sperm during transportation. In addition, I realize that if **all** sperm vials are transported in the same shipping container, there is a risk that **all** sperm may be damaged or destroyed.

I agree to indemnify or repay CRM/ART and its board members, physicians, representatives, employees and agents for any attorney's fees, court costs, damages, judgments, or any other losses or expenses, with respect to any claim or legal action involved in arising out of the transport/shipping of my cryopreserved sperm, except those losses or expenses resulting solely from fault of CRM/ART.

I also certify that the undersigned individual is the rightful owner of the sperm sought to be transferred and there are no other individuals who may have an ownership interest in the sperm being transferred.

Patient to Complete Below

_____
Print name

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

_____
Signature

_____ _____
Date | Daytime Phone Number

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: _____