

Patient Name_____

Date of Birth ____

CONSENT TO DISCARD FROZEN SPERM

I/We request that some or all of my/our frozen sperm samples no longer be stored at Boston IVF. I/We request that the vials of frozen sperm be thawed in the laboratory and be discarded.

Note: Homologous sample only require the initials/signatures of the person who produced the sample. Donor samples require the partner signature, if applicable.

I. Choose one of the two options below (one sample type per consent):

A. Homologous Sample (Procured from own body)

Patient's Initials

B. Donor Sample (Donated or Purchased)

Patient's Initials

Partner's Initials (if applicable)

Please list the sperm donor identification code for the vials you wish to discard:

II. Choose one of the two options below regarding the number of vials of sperm to be discarded:

A. I/We desire that <u>ALL</u> vials of frozen sperm stored at Boston IVF be discarded.

Patient's Initials

Partner's Initials (if applicable)

B. I/We desire that **ONLY** sperm frozen on **the following dates** be discarded:

List dates of freeze (month/day/year) _____

Patient's Initials

Partner's Initials (if applicable)



By signing this document, I/we acknowledge that our Boston IVF physician and caregivers have obtained from me/us informed consent to proceed with discarding of frozen sperm. I/We release the physicians, nurses, technicians, and other Boston IVF staff from any responsibilities regarding sperm after they are discarded.

It is required that you have this document witnessed at Boston IVF, if unable because of distance the default is to have this document officially notarized.

Witness of Consent Form (if this form is completed no need to complete notarization form)

Patient Name (print)	Patient S	Signature	Today	's Date (MM/DD/YYYY)
//_/				
PATIENT- TYPE OF PICT	URE IDENT	IFICATION: 🗆 Dr	iver's License	Passport
ID NUMBER:	State/Cour	ntry:	Expiration Date:	Date (MM/DD/YYYY)
Witness Name and Title (p	orint)	Witness Signature		/ / Today's Date (MM/DD/YYYY)
Partner Name (if applicab	le, print) –	Partner Signature		/ / Today's Date (MM/DD/YYYY)
// Date of Birth (MM/DD/YY				
PARTNER - TYPE OF PIC	TURE IDEN	ΓΙFICATION: □ D	river's License 🛛	Passport
ID NUMBER:	State/Cour	ntry:	Expiration Date:	/ / Date (MM/DD/YYYY)
Witness Name and Title (p	orint)	Vitness Signature		/ / Today's Date (MM/DD/YYYY)



Notarization Form (This form is only needed if not able to have witnessed at Boston IVF)

Patient Name (print)	Patient Signature	/ / Date of Birth (MM/DD/YYYY)
State of: County of:		
On this day of	20, before me, the u	ndersigned notary public, personally appeared
	, proved to me th	nrough satisfactory evidence of identification,
which were	, to be the person whose name is sig	ned on the proceeding or attached document in
my presence.		
ID NUMBER:	Expiration Date:(/ / MM/DD/YYYY)
/ / Today's Date (MM/DD/YYYY)	Notary Signature	
	Title	
	My appointment expires:(MM/DI	/ / D/YYYY)
Partner Name (if applicable, print)	Partner Signature	/ / Date of Birth (MM/DD/YYYY)
State of: County of:		
On this day of	20, before me, the u	undersigned notary public, personally appeared
	, proved to me t	hrough satisfactory evidence of identification,
which were	, to be the person whose name is sig	gned on the proceeding or attached document in
my presence.		
ID NUMBER:	Expiration Date:(MM/	/ / DD/YYYY)
/ / Today's Date (MM/DD/YYYY)		
- Sony S 2 me (Notary Signature	
	Title	
	My appointment expires: /////MM/DD	/ //YYYY)