BOSTON IVF

CONSENT TO DISCARD
FROZEN SPERM

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

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

A. I desire that **ALL** vials of frozen sperm stored at Boston IVF be discarded. _____
Patient's Initials

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

List dates of freeze (month/day/year) _____ _____
Patient's Initials

I release the physicians, nurses, technicians, and other Boston IVF staff from any responsibilities regarding the sperm after it is thawed. I have had an opportunity to discuss this decision with the Boston IVF staff and understand the implications of this decision. I have been given the opportunity to ask questions which have been answered to my satisfaction in language that I understand by the staff of Boston IVF and I have considered alternative options.

_____ _____
Signature of Patient Signature of BIVF Witness

_____ _____
Printed Name Printed Name of BIVF Witness

_____ _____
Date of Birth ID Type

_____ _____
Telephone # ID Number and Exp Date

_____
E-mail

_____
Date

_____(State)

On this ____day of _____, 201___, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were_____, to be the person whose name is signed on the proceeding or attached document in my presence.

_____
Notary Public