

CONSENT TO DISCARD FROZEN DONOR SPERM

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

Please list the sperm donor identification # _____ for the vials you wish to discard.

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

1. I desire that **ALL** frozen sperm samples stored at Boston IVF be discarded. _____
Patient's Initials

2. I desire that **ONLY** frozen sperm samples transported to BIVF on **the following dates** be discarded:

List dates of (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.

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.

_____ Patient Signature	_____ Date	_____ Signature of BIVF Witness
_____ Printed name		_____ Printed Name of BIVF Witness
_____ Date of Birth	_____ Telephone #	_____ ID Type/ID Number/ Exp Date
_____ Street Address / Apt #	_____ E-mail address	
_____ City, State, Zip Code	_____ (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

