Ohio Reproductive Medicine

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 Ohio Reproductive Medicine. 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 **ALL** vials of frozen sperm stored at Ohio Reproductive Medicine 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)

Ohio Reproductive Medicine

By signing this document, I/we acknowledge that our Ohio Reproductive Medicine 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 Ohio Reproductive Medicine staff from any responsibilities regarding sperm after they are discarded.

It is required that you have this document witnessed at Ohio Reproductive Medicine, 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 Signature** **Today's Date** (MM/DD/YYYY)

_____/_____/_____

Date of Birth (MM/DD/YYYY)

PATIENT- TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: ___

ID NUMBER:_____State/Country:_____Expiration Date: _____/_____/_____

Date (MM/DD/YYYY)

_____ _____ _____/_____/_____

Witness Name and Title (print) **Witness Signature** **Today's Date** (MM/DD/YYYY)

_____ _____ _____/_____/_____

Partner Name (if applicable, print) **Partner Signature** **Today's Date** (MM/DD/YYYY)

_____/_____/_____

Date of Birth (MM/DD/YYYY)

PARTNER - TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: _____

ID NUMBER:_____State/Country:_____ Expiration Date: _____/_____/_____

Date (MM/DD/YYYY)

_____ _____ _____/_____/_____

Witness Name and Title (print) **Witness Signature** **Today's Date** (MM/DD/YYYY)

Notarization Form **(This form is only needed if not able to have witnessed at Ohio Reproductive Medicine)**

Patient Name (print)	**Patient Signature**	**Date of Birth (MM/DD/YYYY)**
_____	_____	____/____/____

State of:_____ County of: _____

On this _____ day of _____ 20____, 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.

ID NUMBER:_____ Expiration Date: ____/____/____ (MM/DD/YYYY)

____/____/____
Today's Date (MM/DD/YYYY)

_____
Notary Signature

_____
Title

My appointment expires: ____/____/____ (MM/DD/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 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.

ID NUMBER:_____ Expiration Date: ____/____/____ (MM/DD/YYYY)

____/____/____
Today's Date (MM/DD/YYYY)

_____
Notary Signature

_____
Title

My appointment expires: /____/____ (MM/DD/YYYY)