FERTILITY CENTERS OF ILLINOIS - "FCI"
AND GAMETE RESOURCES, INC.-"GRI"
CONSENT TO DISCARD CRYOPRESERVED SPERM, TESTICULAR TISSUE AND/OR EPIDIDYMAL ASPIRATE ("SPECIMEN")

(For Office Use: Apply Patient Label Here)

NOTE: THIS WRITTEN CONSENT IS AN IMPORTANT DOCUMENT AND THE COPY PROVIDED TO YOU SHOULD BE RETAINED WITH OTHER VITAL RECORDS FOR FUTURE REFERENCE.

I/We being the rightful and legal owner of the specimens(s) herein no longer wish to retain this specimen(s) for use in attempting to establish a pregnancy. The specimen(s) I/we wish to have discarded is presently stored in the care of "FCI" and "GRI", and is identified by the following information:

PATIENT & PARTNER TO COMPLETE

Patient Name:_____ Date of Birth: _____

Partner Name (if applicable):_____ Date of Birth: _____

FOR LAB USE ONLY

Date of Cryopreservation (Printed on Vessel Housing Specimen)	Identification Number (Printed on Vessel Housing Specimen)	Name on Vials/Straws of Specimen	Partner or Donor	Ejaculate/Aspirate Testicular Tissue (Biopsy/Homogenate)
_____, _____				
_____, _____				
_____, _____				

Vials Cryopreserved:_____ Vials Thawed:_____ Vials to Remain Cryopreserved at "FCI and GRI":_____

The specimen(s) has been identified unequivocally by:

"FCI" and "GRI" Representative Signature Title

PATIENT & PARTNER TO COMPLETE

_____ Patient's Initials

_____ Partner's Initials

I/We have had the opportunity to fully consider my/our decision to discard the specimen(s) specified herein and understand that removal of this specimen(s) from cryogenic storage will, in time, render it/them no longer suitable for the purpose of attempting to establish a pregnancy. With this understanding, I/we hereby authorize "FCI" and "GRI" to remove the specimen(s) identified herein from cryogenic storage and direct that this specimen(s) be discarded and used for no other purpose.

PATIENT & PARTNER TO COMPLETE

_____ Patient's Initials

_____ Partner's Initials

I/We would like to discard **all** cryopreserved sperm, testicular tissue and /or epididymal aspirate specimens.

OR

I/We would like to discard only the cryopreserved sperm, testicular tissue and/or epididymal aspirate specified below and cryopreserved on the following dates and/or with the following donor #.

_____ Patient's Initials

_____ Partner's Initials

Quantity-# of vials	Cryopreservation Date	Donor # (if applicable)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Consents signed outside the practice must be notarized and dated.

FOR PATIENT TO COMPLETE

Patient Signature (if applicable):_____ _____ Date

Patient Printed Name:_____

FOR NOTARY USE

Notary Stamp for Patient Signature

_____
Witness/Notary Signature for Patient

_____
Witness/Notary Printed Name for Patient

_____
Date

FOR PARTNER TO COMPLETE

Partner Signature (if applicable):_____ _____ Date

Partner Printed Name:_____

FOR NOTARY USE

Notary Stamp for Partner Signature

_____
Witness/Notary Signature for Partner

_____
Witness/Notary Printed Name for Partner

_____
Date