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

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

PLEASE INITIAL

_____ 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.

Consents signed outside the practice must be notarized and dated.

FOR PATIENT TO COMPLETE

Patient Signature:_____ _____ Date

Patient Printed Name:_____

FOR USE BY PATIENT'S NOTARY

Notary Stamp for Patient Signature

_____ Witness/Notary Signature for Patient

_____ Witness/Notary Printed Name for Patient

_____ Date

FOR PARTNER TO COMPLETE

Partner Signature (if aplicable):_____ _____ Date

Partner Printed Name:_____

FOR USE BY PARTNER'S NOTARY

Notary Stamp for Partner Signature

_____ Witness/Notary Signature for Partner

_____ Witness/Notary Printed Name for Partner

_____ Date