Delaware Institute for Reproductive Medicine, P.A.
dreams, science, reality

Consent for Disbursement of Cryopreserved Sperm

I, _____, have chosen to discontinue with the storage of my cryopreserved sperm. I agree to allow my sperm to be released from my ownership. As a condition of relinquishing my rights I am in turn forfeiting any future financial responsibility, but I am culpable for the arrears. I am requesting that my frozen sperm is to be:

_____ thawed and destroyed.

_____ donated for research purposes only, to further reproductive science success.

_____ donated to a couple that desires donor/donated sperm. Our policy is that anonymity is always maintained. *(This option is for frozen sperm samples obtained from a reputable donor cryobank only.)*

I have read the foregoing and understand the legal ramifications attending this decision. I have been advised to seek independent counsel regarding the chosen choice. I had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I hereby sign this informed consent understanding all risks and ramifications associated with these therapeutic treatments. By executing this form I release all employees, physicians, representatives and all financial associates and holdings of the Delaware Institute for Reproductive Medicine of responsibility and liability.

**** Picture ID with signature for patient and partner must accompany this completed request form.****

Date:_____

Patient Name:_____ **Partner Name:_____**

Patient Signature:_____ **Partner Signature:_____**

Patient SS#:_____-_____-_____ **Partner SS#:_____-_____-_____**

Witness Name:_____ **Witness Signature:_____**

OFFICE USE

ID type of patient with contractual control: circle *Picture ID or Other:*_____
Copy attached: circle *Yes or No* *Billing / Inventory Updated:* circle *Yes or No*
*DIRM Representative Initials:*_____