CONSENT TO DISCARD/DONATE CRYOPRESERVED SPERM AND ASSOCIATED REPRODUCTIVE TISSUE

TERMINATION OPTIONS

Select <u>One</u> Termination Option by Initialing in the Block Provided for that Option

DISCARD

Patient Initials to Discard

Virginia IVF will terminate the cryopreservation and discard the thawed sperm and associated reproductive tissue according to its practice.

FEES: **Storage fees stop accruing the day that this original, fully completed and notarized or witnessed form is received by Virginia IVF. Storage billing is retroactive, final charges will be added and billed unless they are paid in person.**

DONATE TO A KNOWN RECIPIENT

Patient Initials to Donate

Donate the sperm and associated reproductive tissue to a known recipient: Name_____
Phone # _____ Address_____
By selecting this option, I understand that it may be necessary for me to undergo medical and genetic screening, and to seek independent legal counsel for this directed donation. ***Please provide email address below.***

Medical and Genetic Information is not required if the sperm/tissue was collected from an FDA eligible sperm donor.

FEES: **The recipient of the sperm/tissue must sign a consent to assume responsibility for the storage fees. Storage fees stop accruing on the Patient's account on the date the storage consent is signed by the recipient. Storage billing is retroactive, final charges will be added and billed unless they are paid in person.**

SIGNATURE AND EMAIL ADDRESS

I _____ (patient, referred to as "Patient") hereby request that the Virginia IVF and Andrology Center
print full legal name
(referred to as "Virginia IVF") discard or donate, as selected by my initials above, all of my sperm and associated reproductive tissue.
I understand that having this form notarized or witnessed at Virginia IVF is ***required*** and that the options are:

Notarized: This completed form must be **notarized** and this original form mailed or delivered to:
Virginia IVF & Andrology Center, 9030 Stony Point, Suite 390, Richmond, VA 23235
OR
Witnessed: I may come into Virginia IVF, Monday through Friday from 8am until 3:30pm, with a photo ID and a member of our staff will witness the completion of this consent.

Patient's (or Parent if Patient is a Minor) Signature _____ Social Security Number _____ Date _____

Please provide an email address for donation to known recipient _____
You will be contacted via this email address to complete our medical/genetic questionnaire

NOTARY SIGNATURE

Notary Signature _____ **Date** _____

Affix Notary Seal Here **Commission Expires** _____

VIRGINIA IVF USE ONLY

Type of Photo ID Verified:_____
Received by:_____ Date:_____
Received Name (print): _____
Final Bill Generated: Y N Note:_____
Completed by:_____Date:_____
___ Discarded Verified by:_____
___ Donated Verified by:_____