EMORY
REPRODUCTIVE CENTER

550 Peachtree St. Suite 1800, Atlanta GA 30308
(404) 778-3401 FAX (404) 686 4501 CLIA ID 11D0897047

**Place Patient Sticker Here*

Name: _____

MRN: _____

DOB: _____

CONSENT FOR DISPOSAL OF FROZEN SEMEN

I, _____ , _____, (person who owns the specimen (s), referred to herein
Patient Name Date of Birth
as "Patient") own semen specimen(s) which are frozen for storage at the Emory for Reproductive Center of the Emory Clinic, Inc. (referred to herein as "Emory").

I, Patient, no longer desire to maintain storage of the frozen semen and hereby instruct Emory to thaw and dispose of all such semen specimens belonging to me.

I, Patient, attest that these instructions concerning disposition of my frozen semen represent my present desires and that any prior instructions given to Emory concerning storage and disposition of these materials are null and void.

CONSENT

I, Patient, understand that the instructions given in this document are irrevocable. That upon receipt of this document, Emory will act upon the instructions given herein, the results of which are not reversible. I accept the conditions, risks and limitations associated with these instructions. I therefore voluntarily consent to Emory acting upon my instructions to thaw and dispose of my frozen semen specimens. I am 18 years of age or older.

RELEASE

I agree to absolve, release, indemnity, protect and hold harmless the Emory Clinic, Inc., its officers, directors, agents and employees from any and all liability for any adverse outcome, however remote, arising from disposal of my frozen semen specimen(s) as instructedherein.

_____	_____	_____
Signature of Patient	Date	Time
_____	_____	_____
Signature of Staff Member	Date	Time
OR		
_____	_____	_____
Print Name of Notary Signature of Notary	Date	Time

Seal

Instructions to Patient

In order for this consent for disposal of the semen to be acceptable, we must receive a copy of the notarized form from the Patient. This form can be sent via patient portal, or mailed to Emory at the address below. Alternatively, the Patient may sign this form in the presence of an Emory Reproductive Center staff member with a state-issued ID.

Emory Reproductive Center
Attn: Clinic Operations Manager
550 Peachtree St., Suite 1800
Atlanta, GA 30308