



Center for Reproductive Medicine • Advanced Reproductive Technologies

www.ivfminnesota.com

DIRECTION FOR DISPOSITION OF FROZEN SPERM

Patient to Complete Below

Print name	XXX-XX-
Date of Birth (mm/dd/yyyy)	Last 4 digits of SSN
Signature	

Date	Daytime Phone Number
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(Check the box that applies)

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Discard

I, the undersigned, having previously consented to cryopreservation and/or storage of sperm at the CRM Andrology Laboratory, now request that the surplus cryopreserved sperm be discarded.

I understand that by choosing to discard the sperm; no offspring will result. I freely, voluntarily, and willingly direct and authorize Advanced Reproductive Technologies and the Center for Reproductive Medicine, (collectively, ART/CRM) to discard all of the cryopreserved sperm and release ART/CRM and their board members, physicians, employees and representatives and all their agents from all claims of any nature arising from or related to the discarding of the sperm.

☐

Transfer

Transport the frozen sperm to the facility shown below. I understand that ART/CRM is not responsible for any damage to the frozen sperm that may occur during or after transport, and I release it from any liability for the same.

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Please sign in our presence or have notarized

On this ____ day of _____, 20____ before me, personally appeared _____, known to me to be the person described in and who executed the foregoing instrument, and severally acknowledged that they executed the same.

Notary Public (if not signed in our presence)

State of _____

County of _____

My commission expires: _____

(Notary stamp here)

Laboratory Witness (if applicable): _____

Print Name

Sign

Driver's License # patient: _____

Date: _____ Pt ID: _____