

THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES

CONSENT TO THE DISPOSAL OF CRYOPRESERVED MATERIALS IN STORAGE  
("Disposal Consent")

PLEASE READ CONSENT CAREFULLY PRIOR TO EXECUTING

Female Name: \_\_\_\_\_ Female Date of Birth: \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_

Male Name: \_\_\_\_\_ Male Date of Birth: \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_

Partner Name: \_\_\_\_\_ Partner Date of Birth: \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

We (I) \_\_\_\_\_, the couple (individual) whose signature(s) appear below, request and hereby give consent for the disposal of our (my) cryopreserved materials by The Center for Advanced Reproductive Services, PC (The Center), and, as appropriate, its employees, contractors, consultants and authorized agents.

We (I) request that the Center dispose of our (my):

Please check each box that applies:

- Frozen Embryos  
(Requires names and signatures of both members of the couple who signed the original cryopreservation consent for embryo disposal)
- Frozen Sperm, Epididymal Sperm and/or Testicular Tissue  
(Requires male name and signature only)
- Frozen Donor Sperm  
(Requires female name and signature only)
- Frozen Oocytes  
(Requires female name and signature only)

We (I) acknowledge this disposal consent requires the signature of both members of the couple who signed the original cryopreservation consent for embryo disposal, of the male partner only for sperm, epididymal and/or testicular tissue disposal and of the female patient for donor sperm or oocytes. We (I) understand that if we (I) inherited these cryopreserved materials for our (my) own use or obtained the cryopreserved materials for use from a known donor, copies of these agreements and/or consents must be provided along with this consent. In that case, only the signature of the individual(s) involved in that agreement is (are) required.

We (I) understand that, after proper completion of this form, the cryopreserved embryos or cryopreserved sperm, epididymal and/or testicular tissue or oocytes will be discarded according to the Ethical Guidelines of the American Society for Reproductive Medicine (formerly the American Fertility Society). These cryopreserved materials will no longer be available for use in any assisted reproductive technology (ART) or other fertility treatment or procedure.

**This is a two page consent.**

**NOTE: If more than one signature is required, ALL signatures must be notarized. If all partners cannot appear before the notary at the same time, then the form can be duplicated and each partner can sign separately.**

**Please refer to Page 1 for required signatures.**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Male Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Female Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Partner Signature \*\*\* **If no partner, write N/A**

**Note: Notarization of ALL signatures is required.**

State of Connecticut )  
County of \_\_\_\_\_ )

On \_\_\_\_\_, before me, \_\_\_\_\_ (Insert name of

Notary), personally appeared

\_\_\_\_\_ (List

**only the names of individuals who actually appeared for this signature**), personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature \_\_\_\_\_ (Seal)

**THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES MUST RECEIVE THIS CONSENT FORM PRIOR TO THE DISPOSAL OF THE MATERIALS. THIS FORM MAY BE MAILED TO:**

Andrology Laboratory  
The Center for Advanced Reproductive Services  
Dowling South Building  
263 Farmington Avenue  
Farmington, CT 06030-6226  
Tel: 860-679-3460

**CARS Representative Signature:** (for lab use only)

This consent has been discussed with the patient and/or her partner, if any by a CARS staff member.

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date CARS Representative Signature