

**THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES**

**CONSENT FOR CRYOPRESERVATION AND/OR STORAGE OF SEMEN, EPIDIDYMAL AND/OR TESTICULAR TISSUE**

Male Name: \_\_\_\_\_ Male ID # \_\_\_\_\_

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

\_\_\_\_\_

I, the undersigned, request, authorize and consent to cryopreservation and/or storage of semen, epididymal and/or testicular tissue by The Center for Advanced Reproductive Services, PC (The Center), and as appropriate, its employees, contractors, consultants and authorized agents.

I consent to The Center storing my semen, epididymal and/or testicular tissue for my future use. I understand this may require collection of several semen specimens. Each specimen is analyzed, divided into vials and frozen. I understand that there are risks inherent in this procedure. These include, but are not limited to, damage to sperm as part of the freezing and thawing process, reduced fertilization capacity or a reduced capacity to produce a pregnancy. While there is no evidence that freezing of sperm or testicular tissue increases the risk of birth defects or pregnancy complications, such defects or complications may occur at the same rate as would be seen with fresh sperm.

My samples will only be used for my own medical treatments or that of my partner and/or designee. At no time will the specimens be sold or used for insemination of any other individual unless I consent to donate them. My samples will be available for my use only if my account is paid in full.

I understand that both the cryopreservation and storage procedures involve the use of mechanical and/or electrical equipment. The Center will take reasonable measures to maintain and monitor this equipment. However, despite their best efforts, equipment failure may result in the damage or loss of one or more vials of my semen or testicular tissue. I understand and agree that The Center shall be responsible only for acts of negligence on its part and the part of its employees, contractors, and consultants.

**I understand and agree that my samples will be stored by The Center for one year and that the first year of storage is included in my cryopreservation fee. After the initial one year storage period is completed, I will be billed for storage on a quarterly basis. I understand it is my responsibility to notify The Center prior to the one year anniversary date of the initial cryopreservation to inform them of my intent to dispose of my samples.**

**I understand and agree that storage billing will begin the quarter after the anniversary date of this contract, and will continue prospectively every quarter thereafter. Failure to pay storage fees in a timely manner will result in appropriate collection actions.**

I understand and accept The Center's storage and billing policy for semen, epididymal and/or testicular tissue.

\_\_\_\_\_  
(Male partner initials)

I understand it is my obligation to notify The Center of any change of address, and that if I do not do so, The Center is not liable for its inability to contact or bill me. If I fail to do so or I cannot be reached or do not respond to correspondence received from the Center after one year, I understand and agree that the sperm or tissue specimens will be considered abandoned and will be discarded by the Center according to American Society for Reproductive Medicine Ethical Guidelines.

I understand that I may decide, at any time, to terminate this agreement and have the specimens destroyed (after signing a disposal consent) or to transfer them to another fertility center or long term storage facility (after signing a consent to transfer samples out), and that the costs and responsibilities are mine. If I choose to destroy my specimens all storage fees will continue to accrue until The Center receives a properly executed Disposal Consent.

Upon my death I intend that these samples will (choose one of the options below):

- 1. Be destroyed **OR**
- 2. Be transferred to my designee \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**(Write in designee name, address and phone number)**

I release The Center from responsibility for the outcome of the freezing and thawing process, including the release of responsibility for occurrence of pregnancy, outcome of pregnancy, including birth defects, and transmission of any infectious disease or genetic abnormality through insemination with this sperm.

Semen and/or Testicular Tissue Cryopreservation has been explained to me, together with the known risks. I have been advised that there are possible unknown risks. I understand the explanation that has been given to me. I have had the opportunity to ask questions and those questions have been answered to my satisfaction. I acknowledge that sperm, epididymal and/or testicular tissue cryopreservation and/or storage is being performed at my request and with my consent.

***This consent must be signed by the male patient for samples he has provided.***

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

**Note: Notarization of MALE signature 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 TRANSFER OF THE MATERIALS. THIS FORM MAY BE MAILED TO:

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

**Physician Signature: (for lab use only)**

This consent has been discussed with the patient and her partner, if any.

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature