

**CENTER FOR ADVANCED REPRODUCTIVE SERVICES
CONSENT TO THAWING AND UTILIZATION OF FROZEN SEMEN, EPIDIDYMAL AND/OR TESTICULAR
TISSUE**

Male Name: _____ Male ID# _____

Address: _____

I the undersigned, request, authorize and consent to the thawing and utilization of my cryopreserved (frozen) semen, epididymal and/or testicular tissue stored by The Center for Advanced Reproductive Services, PC (The Center), and as appropriate, its employees, contractors, and consultants and authorized agents for us in an attempt to achieve a pregnancy.

I understand that there is no guarantee that any of the sperm or tissue will survive the thawing process. Furthermore, I understand also that there is no guarantee that the use cryopreserved (frozen) sperm, epididymal and/or or testicular tissue will result in a conception. I understand and consent that the number of vials of cryopreserved (frozen) sperm, epididymal and/or testicular tissue thawed is at the discretion of The Center staff.

I understand that the process of utilizing the cryopreserved (frozen) sperm, epididymal and/or or testicular tissue will involve the use of In Vitro Fertilization, Intrauterine Insemination or another treatment. My partner and I (we) must execute separate consents for those treatments.

I understand, agree and consent that my cryopreserved (frozen) sperm or testicular tissue may only be used to produce a pregnancy in my designated sexually intimate partner listed below:

Designated Sexually Intimate Partner:

I understand, agree and consent that these samples may not be used by a non-sexually intimate partner and that I must execute a consent to act as an identified donor and undergo all federally mandated screening and testing for this purpose.

I agree and consent that I will be contacted periodically by phone, mail or during visits to the Center to verify my continued participation and consent to this treatment and may withdraw my consent at any time by notifying the Center in writing.

I understand, agree and acknowledge that I am not married to a woman who is not a party to this informed consent.

Thawing and utilization of my cryopreserved (frozen) sperm or testicular tissue has been explained to me, together with the known risks. I understand the explanation that has been given to me. I have had the opportunity to ask any questions I might have and those questions have been answered to my satisfaction. Any further questions I might have may be addressed to The Center staff or IVF/ET Program Director, Dr. John Nulsen at (860) 679-4580. I acknowledge that Thawing and Utilization of my frozen sperm, epididymal and/or testicular tissue is being performed at my request and with my consent.

I acknowledge that this consent must be notarized and signed by the same individual who executed the original cryopreservation consent.

I understand, agree and acknowledge that I am not married to someone who is not my designated recipient.

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

_____/_____/_____
Date Male Signature _____

Note: Notarization of BOTH 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 TRANSFER OF THE MATERIALS. THIS FORM MAY BE MAILED TO:

John Nulsen, MD, Program Director
The Center for Advanced Reproductive Medicine
Dowling South Building
263 Farmington Avenue
Farmington, CT 06030
Tel: 860-679-4580

Physician Signature:

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

_____/_____/_____
Date Physician Signature _____

