Authorization to Discard Cryopreserved Semen Specimens

Fertility and Reproductive Medicine Center - Andrology Laboratory
Washington University Physicians and Barnes-Jewish Hospital

I, _____ authorize the Andrology Laboratory at the Fertility and Reproductive Medicine Center at Washington University to discard my semen specimens. I understand that all sperm stored in my name will be thawed and disposed of in conformance with professional standards. I understand that if I return the completed form in person the Andrology Laboratory will request identification such as a driver's license or other photo ID to confirm my identity prior to discarding my specimens.

If I choose to return the form by mail, I will have my signature notarized and mail the form to:

Fertility and Reproductive Medicine Center, c/o Janet Willand
4444 Forest Park Ave., Suite 3100, St. Louis, MO 63108

I also understand that the Andrology Laboratory at the Fertility and Reproductive Medicine Center at Washington University will not be held liable in any way for my decision.

_____
Reason for Discard

_____ _____
Print Client Name Date of Birth

_____ _____
Client depositor's signature Date signed
The male partner whose sperm is stored must sign this form unless the sperm is from a donor.

_____
Permanent address - Street City State Zip

If you are returning this form by mail it must be notarized

STATE OF _____ COUNTY OF _____

I, _____ , a notary public do hereby certify that _____, known to me to be the same person whose name is signed to this document, appeared before me in person and acknowledged that he signed this document as his free and voluntary act.

Given under my hand and official seal this _____ day of _____ .

Notary Public: _____

My Commission Expires: _____Commission No.: _____

Place Notary Seal above