Consent to Receive and Store Cryopreserved Sperm

I, ______________________________ (Patient), have previously consented to cryopreservation (freezing) and storage of my sperm for future use, at

____ (name of Facility)

____ (street)

____ (city, state, zip)

____ (telephone and fax)

I acknowledge that I currently have ______ vials of sperm cryopreserved and stored with the andrology laboratory at Facility.

I consent to the transfer of all vials of my cryopreserved sperm to the andrology laboratory at Regional One Health (ROH).

I acknowledge that events beyond ROH's control may occur during transport and agree that ROH or UT-Regional One Physicians, Inc. is not liable for any losses associated with the transport of my sperm.

I hereby consent and agree that the employees of the andrology laboratory at ROH, under the supervision of the Laboratory Director, shall have such authority and control over, and access to, my sperm as may be necessary for the performance of their duties, relative to the freezing and custody of my sperm.

I understand that the freezing of sperm may decrease its fertilization potential by adversely affecting the percentage of motile sperm present after being thawed and that such risks are inherent in the freezing and storage process and are beyond the control of the andrology laboratory at ROH. No representations have been made to me concerning the fertility or other condition of my sperm deposited with the andrology laboratory at ROH.

I hereby release the ROH, UT Regional One Physicians, Inc., and their respective agents, directors, officers, and contractors (the "Releasees") from any claim for injury or damage, known or unknown, that might result should my frozen sperm cease to be viable while in the custody of the Releasees.

I acknowledge and agree that in the event of loss, damage or destruction of the sperm occurs for any reason whatsoever, except as provided in the paragraph above, my actual damages as a result thereof would be impracticable or extremely difficult to determine. Accordingly, I agree that, in the event any or all of my stored sperm are lost, damaged or destroyed for any reason, including, without limitations as a result of the negligence of Releasees, I shall be entitled to liquidated damages in the amount equal to the storage fee paid for the term of the storage agreement in which such loss, damage or destruction occurred.

I further release, discharge, indemnify and forever hold harmless the Releasees from any and all liability and responsibility of any nature whatsoever that may result from complications of pregnancy, childbirth, delivery, or from the birth of an abnormal infant or infants in any respect, or from the heredity or hereditary tendencies of such infant or infants, or from any other adverse consequences that may arise in connection with or as a result of the procedures and services discussed herein.

I understand that I may obtain my sperm from the andrology laboratory at ROH at any time upon fourteen (14) days' advance written notice, provided that all amounts due from me are paid in full, including any packing, shipping, or similar charges that may be incurred for transferring or transporting the sperm to another location, as so directed by me.

I am aware and understand that my sperm will be kept in the andrology laboratory at ROH up to one (1) year. If I still have stored sperm remaining after the expiration of the one-year period, they will be shipped by Regional One Health to Fairfax Cryobank (or other cryopreservation storage facility chosen by us) provided that I have (i) signed a storage agreement with the cryopreservation storage facility; (ii) paid the applicable fee for storage to the cryopreservation storage facility; and (iii) ROH has received of notification of such from the cryopreservation storage facility. I understand it is my responsibility to maintain the storage agreement and pay the applicable fee to the cryopreservation storage facility.

I understand that I may choose an entity other than Fairfax Cryobank to provide cryopreservation storage. I further understand and agree that my protected health information (PHI) may be disclosed to the cryopreservation storage facility and I consent to such disclosure.

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In the event that I have not secured an external cryopreservation storage facility for the stored sperm, within the one-year period, **<u>I understand that the stored sperm will be considered abandoned</u>**. If my stored sperm is determined to be abandoned by ROH, I request the following (**initial beside your choice and cross out the other choice**):

______ ______ a. the stored sperm shall be donated to the University of Tennessee Health Science Center (UTHSC) for research purposes. Any research shall be conducted pursuant to applicable federal and state guidelines.

______ ______ b. thaw and destroy all stored sperm. This disposition directs ROH to dispose of the stored sperm in a manner consistent with any federal and state laws one (1) year from the date of cryopreservation.

I am aware and understand that the long term safety or viability of cryopreserved sperm is not completely known. It has been recommended to me that stored sperm be thawed and used in fertility treatments within five (5) years of cryopreservation. However, due to my age at the time of collection, freezing, and storage, I understand that longer storage time may be necessary until I become of age to begin fertility treatments and that records have shown that some sperm thawed after five (5) years have been successfully used in fertility treatments.

If I should die or become mentally incompetent while any of my cryopreserved, stored sperm are still in possession of the andrology laboratory at ROH, I hereby authorize, direct, and consent to the taking of the action I have marked below. I hereby consent thereto (**initial next to your choice and cross out the others**):

a) ______ my surviving, mentally competent and legal spouse or partner at the time of my death or incompetence shall have authority to direct sperm usage or storage;

b) ______ donate all stored sperm to the University of Tennessee Health Science Center (UTHSC) for research purposes as described in the paragraph above; or

c) ______ thaw and dispose of all stored sperm in accordance with applicable federal and state laws.

I fully understand that insurance coverage for any or all of the above procedures may not be available and that I will be personally responsible for the expenses of this treatment and the annual storage fee. The expenses may consist of hospital charges, laboratory charges and/or physician professional fees.

I understand that all information obtained about me during the program will be handled confidentially and that my identity will not be revealed without my consent. However, specific medical details may be revealed in professional publications as long as my identity is concealed.

I understand it is my responsibility to inform the andrology laboratory at ROH of any future changes in my mailing address. My current mailing address is:

____ (street)

____ (city, state, zip)

I acknowledge that I have fully reviewed and comprehend the contents of this consent form. The nature of sperm cryopreservation has been explained to me, together with the known risks. I understand the explanation that has been given me and that there may be unknown risks. I have had the opportunity to ask any questions I might have and those questions have been answered to my satisfaction. I acknowledge that sperm cryopreservation and/or storage is being performed at my request and with my consent. I acknowledge and affirm that I have given my consent and signed this consent form without coercion or compulsion and of my own free will. I acknowledge that a copy of this consent has been given to me.

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____
Patient Signature* Date

____
Parent or Guardian Signature (if patient is a minor)* Date

____
Patient Printed Name

____
Parent or Guardian Printed Name

____
Witness Signature Date

____
Witness Printed Name

Physician Attestation

The above mentioned Patient and Partner (if applicable) have been informed and counseled by me and others regarding the risks and benefits of the relevant treatment options, including non-treatment. The Patient and Partner (if applicable) expressed understanding of the information presented during the discussion.

____
Physician Signature Date

____
Physician Printed Name

[Notary Page to follow]

Consent to Receive and Store Cryopreserved Sperm

[Notary Page for: Consent to Receive and
Store Cryopreserved Sperm]

STATE of ______________________)
) :SS
COUNTY of ____________________)

The foregoing instrument was acknowledged before me this ______ day of ___________, 20____, by _________________________________, referred to in this consent form as “Patient” or parent or guardian of “Patient”.

My commission expires: ____ .

____
Notary Public