Consent to Transfer Cryopreserved Sperm

I, _____ (Patient), the undersigned Patient, have previously consented to cryopreservation (freezing) and storage of my sperm for future use, at the Andrology Laboratory at Regional One Health.

I acknowledge that I currently have _____ vials of sperm cryopreserved and stored with the Andrology Laboratory at Regional One Health.

I consent to the transfer and storage of all vials of my cryopreserved sperm to:

_____ (name of Facility)

_____ (street)

_____ (city, state, zip)

_____ (telephone and fax)

I understand that Andrology Laboratory at Regional One Health will arrange and carry out transport of my sperm to the Facility indicated above at the cost of $250.00. I acknowledge that events beyond the control of Regional One Health may occur during transport and agree that Regional One Health and UT Regional One Physicians, Inc. and their respective employees, directors, officers, and contractors are not liable for any losses associated with the transport of my sperm.

I am aware and understand that the long term safety or viability of cryopreserved sperm is unknown. It has been recommended to me that stored sperm be thawed and used in fertility treatments within five (5) years of cryopreservation.

I am aware and understand that my sperm will be kept in the Andrology Laboratory at Regional One Health (ROH) up to one (1) year. If I still have stored sperm remaining after the expiration of the one-year period, my cryopreserved sperm will be shipped by ROH to Fairfax Cryobank (or other cryopreservation storage facility that I have chosen) 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.

In the event I have not secured an external cryopreservation storage facility for the stored sperm, within the one-year period, **I understand that the stored sperm will be considered abandoned**. 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 performed 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 law one (1) year from the date of cryopreservation.

I acknowledge and agree that I bear the sole responsibility for monitoring the one-year period. I further understand and acknowledge that no further attempts will be made by the Andrology Laboratory at Regional One Health to contact me and ascertain my wishes regarding the stored sperm. I understand that this consent form will constitute the only notification regarding expiration of storage.

Affix Patient Label

Patient's Initials _____

Consent to Transfer Cryopreserved Sperm

If I should die or become incompetent while any of my stored, cryopreserved sperm are still in possession of the Andrology Laboratory at Regional One Health, I hereby authorize, direct, and consent to the taking of the action I have marked below, and I hereby consent thereto (**initial next to your choice and cross out the other choices**):

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

b) _____ donate all stored sperm to 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 law.

I fully understand that insurance coverage for any or all 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 about me obtained during the program will be handled confidentially and that neither my identity nor specific medical details will be revealed without my consent. Specific medical details may be revealed in professional publications provided my identity is concealed.

I understand it is my responsibility to notify the Andrology Laboratory at Regional One Health of any change 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 entered into this consent form without coercion or compulsion and of my own free will.

_____ _____

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]

Affix Patient Label

Patient's Initials _____

[Notary Page for: Consent to Transfer 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