Consent for Cryopreservation (Freezing) and/or Storage of Sperm: Known Donor

I, ______________________________ (Known Donor), wish to use the services and facilities of the Andrology Laboratory at Regional One Health (ROH) for collecting, freezing, storing, and/or keeping custody of my sperm for the recipient(s),

______________________________/______________________________ (Recipients), for use in their fertility treatments, on the conditions set forth in this consent form.

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 for said recipient(s) above.

I acknowledge that my sperm is a gamete only, and that any child or children born from the recipient(s)' use of my sperm is the recipient(s)' legitimate child or children and as such are the legal heirs of the recipient(s). Therein, I have no legal claims or parentage to any child or children born from the use of my sperm by the recipient(s). I agree to this sperm donation, which has no parental rights, and will never enter into any proceedings to lay claim to any child or children born from its use. Further, in the event my sperm is transferred to an external cryopreservation storage facility, as directed below, I understand and agree that my protected health information (PHI) may be disclosed to the cryopreservation storage facility and I consent to such disclosure.

I (We), as the recipient(s), understand that 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 (us) concerning the fertility or other condition of the known donor's sperm deposited with the andrololgy laboratory at ROH.

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

I (We), as the recipient(s), acknowledge and agree that, in the event of loss, damage or destruction of the known donor's sperm occurs for any reason whatsoever, except as provided in the paragraph above, actual damages as a result thereof would be impracticable or extremely difficult to determine. Accordingly, I (we), the recipient(s), agree that, in the event any or all of the known donor's stored sperm are lost, damaged or destroyed for any reason, including, without limitations as a result of the negligence of the Releasees, I (we), the recipient(s), 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, the known sperm donor, and I (We), the recipient(s), further release the Releasees from any and all liability and responsibility of any nature whatsoever that may result from complications of pregnancy, childbirth or 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 process and procedures authorized herein.

I (We), as recipient(s), may obtain the known donor's sperm from the andrology laboratory at ROH at any time upon fourteen (14) days' advance written notice, provided that all amounts due from me (us) 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 (us).

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

I (We), as recipient(s) understand that I (We) may choose an entity other than Fairfax Cryobank to provide cryopreservation storage.

Known Donor Initials ________

Recipient(s) Initials ________ ________

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In the event I (we), as recipient(s) have not secured an external cryopreservation storage facility for the stored sperm, within the one-year period, **I (we) understand that the stored sperm will be considered abandoned**. If the stored sperm is determined to be abandoned by ROH, I (we), as recipient(s) request the following (**both recipients initial beside their 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 an federal and state law one (1) year from the date of cryopreservation.

I (We), said recipient(s), am (are) aware and understand that the long-term safety or viability of cryopreserved sperm is not completely known. It has been recommended to me (us) that stored sperm be thawed and used in fertility treatments within five (5) years of cryopreservation. Records have shown that some sperm thawed after five (5) years have been successful when used in fertility treatments.

If I (we), said recipient(s), should die or become mentally incompetent while any of my (our) cryopreserved, stored sperm are still in possession of the andrology laboratory at ROH, I (we), said recipient(s), hereby authorize, direct, and consent to the taking of the action I (we), said recipient(s) have marked below. I (We) 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 will 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 (We), said recipient(s), fully understand that insurance coverage for any or all of the above procedures may not be available and that I (we) 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 (We), said recipient(s), understand that all information obtained about me (us) during the program will be handled confidentially and that my (our) identity will not be revealed without my (our) consent. However, specific medical details may be revealed in professional publications as long as my (our) identity is concealed.

I (We), said recipient(s) understand it is my (our) responsibility to inform the andrology laboratory at ROH of any future changes in my (our) mailing address. Current mailing addresses for all parties:

Known Donor:

____ (street)

____ (city, state, zip)

Recipient(s):

____ (street)

____ (city, state, zip)

I (We), the known sperm donor and the recipient(s), acknowledge that we have fully reviewed and comprehended the contents of this consent form. The nature of sperm cryopreservation has been explained to us, together with the known risks. We understand the explanation that has been given us and that there may be unknown risks. We have had the opportunity to ask any questions we might have and those questions have been answered to our satisfaction. We acknowledged that sperm cryopreservation and/or storage is being performed at our request and with our consent. We acknowledge and affirm that we have given our consent and signed this consent form without coercion or compulsion and of our own free will.

____
Known Donor Signature Date

____
Known Donor Printed Name

____
Recipient Signature Date

____
Recipient Signature Date

____
Recipient Printed Name

____
Recipient 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 for Cryopreservation (Freezing) and/or Storage of Sperm: Known Donor

[Notary Page for: Consent to Cryopreservation (Freezing) and/or Storage of Sperm: Known Donor]

STATE of ____________________)
) :SS
COUNTY of __________________)

The foregoing instrument was acknowledged before me this ______ day of __________, 20____, by

______________________________, referred to in this consent form as "Known Donor".

My commission expires: ____ .

____
Notary Public

STATE of ____________________)
) :SS
COUNTY of __________________)

The foregoing instrument was acknowledged before me this ______ day of __________, 20____, by

______________________________, referred to in this consent form as "Recipient".

My commission expires: ____ .

____
Notary Public

STATE of ____________________)
) :SS
COUNTY of __________________)

The foregoing instrument was acknowledged before me this ______ day of __________, 20____, by

______________________________, referred to in this consent form as "Recipient".

My commission expires: ____ .

____
Notary Public