## Known Donor Quarantine/Infectious Disease Re-Testing Waiver

I _____ (Patient), waive the six (6) months quarantine of the cryopreserved sperm from _____ (Known Donor), as well as the re-evaluation of said Known Donor's infectious disease testing for HIV I, HIV II, Hepatitis B, Hepatitis C and the RPR for Syphilis.

I acknowledge that my Known Donor has had initial blood drawn and tested for the above infectious diseases and that those results were negative at that time for said infectious diseases. Regional One Health and UT Regional One Physicians, Inc. and their respective physicians, employees and agents have fully explained to me, with my clear understanding and acknowledgement, that the incubation period for aforementioned infectious diseases can be six (6) months. As such, my waiving any re-evaluation of my Known Donor post these six (6) months releases the Regional One Health, UT Regional One Physicians, Inc. and their respective employees, agents, directors, officers, and contractors from any and all liability and responsibility of any nature whatsoever should Known Donor be positive for HIV I, HIV II, Hepatitis B, Hepatitis C and/or RPR for Syphilis. Further, by waiving any re-evaluation of these infectious diseases, I acknowledge and understand that there is a risk of transmission of HIV I, HIV II, Hepatitis B, Hepatitis C and/or Syphilis to myself and possibly the unborn child.

I do not have any further questions or concerns regarding the foregoing and opt to proceed with treatment without the recommended re-evaluation and screening post a six (6) month quarantine of our Known Donor's cryopreserved sperm. Thereby, I, with my signatures below, am accepting on the initial screening and evaluation of the infectious diseases of HIV I, HIV II, Hepatitis B, Hepatitis C and Syphilis performed at the time my Known Donor collected and cryopreserved his sperm for use during my treatment.

With full knowledge and understanding of the attendant risks and consequences of our participation, I consent to the medical procedures of my treatment plan. I/We have had the opportunity to ask questions and all my/our questions have been answered to my/our satisfaction. I acknowledge and affirm that I have waived any and all re-evaluation of my Known Donor for HIV I, HIV II, Hepatitis B, Hepatitis C and Syphilis and have signed this waiver consent without coercion or compulsion and of my own free will.

_____

Patient Signature Date

_____

Patient Printed Name

_____

Witness Signature Date

_____

Witness Printed Name



Affix Patient Label



Patient's Initials _____

**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]

[Notary Page for: Known Donor Quarantine/Infectious Disease Waiver: Patient]

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".

My commission expires: _____ .

_____
Notary Public



Affix Patient Label



Patient's Initials _____