

SPERM CRYOPRESERVATION CONSENT

OHSU Fertility Consultants
Oregon Health and Science University

I, _____, consent to have my sperm or testicular tissue, (referred to here as specimens) cryopreserved and stored at the OHSU Fertility Consultants laboratory. I understand that it is my obligation to pay the processing and storage fees attendant to the cryopreservation of my specimen(s). I acknowledge that it is my obligation to maintain contact with the OHSU Fertility Consultants on an annual basis to direct the ongoing disposition of my specimens.

USE OF SPECIMEN

I understand that, as part of normal storage and testing procedure, a small aliquot (less than 0.5 ml) of each specimen will be thawed and tested to assess the quality of the frozen sperm. I acknowledge that the specimen is to be used only for purposes of the intrauterine insemination (IUI) or with in vitro fertilization (IVF) procedures for my lawful spouse, sexually intimate partner, or other recipient of my choosing. I understand that in no event shall the OHSU Fertility Consultants be required to release any portion of the specimen to any person other than my physician, except as otherwise directed by an order of a court of competent jurisdiction, a last will and testament, or other contract as indicated below.

I understand that the FDA requires donor testing and screening if my samples are to be used by anyone other than my spouse/sexually intimate partner. I understand that I may waive such testing and screening only if my samples are to be used by my spouse/sexually intimate partner. I choose one of the following options:

Initial only
one

_____ **I DECLINE to receive the FDA required donor testing and screening.** I understand that by choosing this option my specimens can only be used by my sexually intimate partner. I acknowledge that under these terms the OHSU Fertility Consultants cannot (by law) release these specimens for use by any other recipient than my spouse/sexually intimate partner.

_____ **I CHOOSE to receive the FDA required donor testing and screening.** I understand that this option may allow my specimens to be used by a recipient other than my sexually intimate partner in the future. In choosing this option I agree to receive blood testing, a physical exam, and risk factor interview within 7 days of specimen collection and 6 month quarantine testing prior to the release of my specimens. I am also aware that I will be responsible for any and all costs associated with the screening and testing. I acknowledge that the OHSU Fertility Consultants cannot guarantee the handling of any blood testing which must be performed off site.

Please initial & date that you have read and understood the following:

Initial

_____ I understand that if I am misleading or misrepresenting my intended use of this specimen(s), and it is discovered as such by the OHSU Fertility Consultants, my specimens will not be released to me and I will be responsible for payment of ALL services performed.

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ASSIGNMENT IN CASE OF DEATH

In the event of my death while my specimens are in cryostorage, or if I am rendered incapable of making any conscious decisions or rendered mentally incompetent, I elect one of the following for disposition of my specimens:

Initial only
one

_____ That control of my specimens be given to my spouse/sexually intimate partner:
(indicate name and address)

_____ That my specimens be disposed of in a medically appropriate manner.

_____ That control of my specimens be given to the following person (indicate name and address)

I understand that, unless I have undergone FDA screening and testing, these specimens cannot be used by anyone other than my spouse/sexually intimate partner.

CONDITIONS OF STORAGE

I acknowledge that the OHSU Fertility Consultants, their staff or representatives provide no warranties with respect to 1) the viability or motility of the client's frozen sperm cells or testicular tissue; 2) the possibility of the successful use of the specimen(s) at any time; 3) the infallibility of cryopreservation equipment and storage vessels. I acknowledge that cryopreservation and storage requires mechanical support and that backup systems are in place. However, I also acknowledge that unforeseen conditions may occur that could render my specimens nonviable and I do not hold the OHSU Fertility Consultants liable for such situations, including malfunction of the liquid nitrogen storage vessels, failure of any utilities, any strike, cessation of services or other labor disturbances, any fire, earthquake, flood or any other acts of nature. I further acknowledge that the OHSU Fertility Consultants is not responsible for 1) the risk of a birth defect or miscarriage after an IUI or IVF procedure with the use of the my specimen(s); 2) the possibility of complications in pregnancy and delivery after use of the my specimen(s) in an IUI or IVF procedure. I understand that the risks to any pregnancy and complications with labor and delivery are the same following the use of frozen sperm or testicular tissue as that for the use of fresh sperm. I further acknowledge that the viability, motility and capacity to fertilize of the frozen sperm cells vary from specimen to specimen and that no guarantees are made regarding my specimens. I also understand that no guarantee of any kind can be made with respect to the possibility of the successful use of my specimens in an IUI or IVF procedure.

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OBLIGATION

I acknowledge that it is my obligation to maintain contact with the OHSU Fertility Consultants and provide payment for annual storage fees for my specimens. I understand that if I fail to do so that my specimens will be discarded after 60 days from the date of expiration of my annual renewal. I also acknowledge that I may direct the OHSU Fertility Consultants to do one of the following while my specimens are in cryostorage:

1. I may elect to continue cryostorage of my specimens after payment of storage fees.
2. I may elect to have some/all of my specimens to be used for an IUI or IVF procedure by my spouse/sexually intimate partner.
3. I may elect to have my specimens thawed and disposed of at any time.
4. I may elect to have my specimens transferred to another facility. I understand that there would be costs associated with such a transfer.
5. I may elect to donate my specimens to another person for their use. I understand that I may do so only if I have undergone FDA screening and testing.

I agree that the OHSU Fertility Consultants, its staff or representatives shall not be liable for any destruction or damage to, or misuse of my frozen specimens, the improper maintenance, withdrawal, thawing, and/or deliver of the specimen or any other matter, unless such destruction, damage, misuse, improper testing, freezing, maintenance, storage, withdrawal, thawing, and/or delivery or other matter is caused by or results from the gross negligence of the OHSU Fertility Consultants.

I agree to all of the terms and conditions set forth in this document and consent to have my sperm cryopreserved and stored by the OHSU Fertility Consultants.

Print Patient Name

Patient Signature

____ / ____ / ____
Date

Parent or Legal Guardian Signature (if appl.)

____ / ____ / ____
Date

OHSU Fertility Consultants Staff Signature

____ / ____ / ____
Date