



Fertility Storage, Inc.
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Warren, MI 48092
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CONSENT FORM FOR CRYOPRESERVATION AND STORAGE OF HUMAN SEMEN/TESTIS TISSUE

I, _____, a married / unmarried male, (circle one)
(male name)

residing at _____,
(male's address)

do hereby request the cryopreservation and storage of my semen/testis tissue by the Michigan Center for Fertility and Women's Health, PLC (MCFW)/Fertility Storage, Inc (FSI) for use in an Intrauterine Insemination (IUI) or In Vitro Fertilization (IVF) procedure.

Please initial one selection below:

- _____ I understand that I am providing my sperm to be used for fertilization of oocytes from _____, with the intention of fatherhood.
- _____ I understand that I am providing my sperm to be used for fertilization of oocytes from _____, with the intention of being a directed (known) sperm donor.
- _____ I understand that I am providing my sperm to be used for fertilization of donor oocytes owned by _____, with the intention of fatherhood.
- _____ I understand that I am providing my sperm to be used for fertilization of donor oocytes owned by _____, with the intention of being a directed (known) sperm donor.
- _____ I understand that I am providing my sperm strictly for cryopreservation at this time.

I. FACTS

It is generally accepted by cryobiologists and the Reproductive Council of America of Tissue Banks that cryopreservation and storage of semen/testis tissue is a useful and safe procedure, which maintains the potential reproductive function of human sperm after storage in liquid nitrogen.

Cryopreservation and thawing of human semen/testis tissue usually results in decreased sperm concentration and motility.

II. PROCESS

I understand that the process of semen/testis tissue cryopreservation and storage involves:

Semen/Testis tissue freezing which consists of semen dilution with a cryoprotective solution, placing the semen in small tubes, cooling, freezing and storing the specimens in liquid nitrogen.

III. RISKS ASSOCIATED WITH SPERM STORAGE

I understand that:

1. Cryopreservation and thawing of human semen/testis tissue generally result in decreased motility(movement) and sperm concentration(count). There is also the possibility that none of my sperm/testis tissue will survive the cryopreservation procedure.
2. There is no guarantee that a pregnancy will result from the use of my cryopreserved specimen.
3. Although there is no evidence of increased birth defects from the use of cryopreserved semen/testis tissue, a risk of miscarriage, stillbirth or congenital anomalies still exist as with any pregnancy.
4. A laboratory accident may occur and result in the loss or damage of one or more specimens.

IV. FINANCIAL RESPONSIBILITY

1. I understand that insurance coverage may not be available for this procedure. Therefore, I agree to be personally responsible for the expenses of cryopreservation. These expenses include the fee for cryopreservation and processing per specimen. An additional annual storage fee of **\$300.00** will be billed on a yearly basis if I desire to continue the tissue storage at the Fertility Storage, Inc (FSI) for longer than one year. This annual billing will begin on _____, 20__.
2. I understand that all storage fees must be paid in advance on an annual basis. **It is my responsibility to notify the Michigan Center for Fertility and Women's Health, PLC or Fertility Storage, Inc. of any change in my address so that they may notify me of the annual charges. I understand and hereby agree that my failure to provide the Michigan Center for Fertility and Women's Health, PLC or Fertility Storage, Inc. with my current address and/or to pay storage fees will result in discontinuation of the specimen(s) storage.**

**Fees are subject to change without notice.*

V. OWNERSHIP OF SEMEN SPECIMEN

In the event of my death or disability (defined as my inability to make decisions regarding the use of my sperm and supported by written letter from attending physician), I hereby desire and direct that ownership and control as to the use or disposition of my stored semen/testis tissue specimen(s) will be held by:

(Check and initial ONE of the following options)

- _____ 1. I direct that my semen/testis tissue be thawed and medically disposed in accordance with the company policies.
- _____ 2. I direct that my semen/testis tissue be thawed and used for IUI or IVF of my partner, _____
(Name of the designated person)
- _____ 3. Other (Specify) _____

The directions in this form bind the male patient and his heirs, legal representatives, assigns and successors.

The potential risks and benefits of semen/testis tissue collection, freezing and storage have been explained to me. I understand that there is risk of sperm/testis tissue damage as a result of the freezing and thawing process. I certify that I have read and understand this consent and have been given the opportunity to ask any questions I may have about this procedure.

I do hereby expressly release, discharge and hold harmless both on my behalf as well as on behalf of my heirs and assigns the Michigan Center for Fertility and Women’s Health, PLC, its physicians, employees and other agents from any and all claims of liability which I or my heirs and assigns have or might have, arising out of or resulting from the collection, cryopreservation, thawing and storage of my semen/testis tissue, including any and all claims of liability for the conception of a child by my frozen sperm who may be born with birth defects, or to the loss, misplacement or mishandling of my sperm/testis tissue.

Printed Name of Patient

Signature of Patient

Date

Signature of Michigan Ctr for Fertility Witness

Date