Strong Fertility Center
500 Red Creek Dr., Suite 220, Rochester, NY 14623
585-487-3378

CONSENT TO DISCARD FROZEN STORED SPERM

I _____authorize the Strong Fertility Center at University of Rochester Medical Center (URMC) to discard all of my stored frozen sperm. I have enclosed **a copy of my driver's license** by way of identification.

Signed_____

Date_____

For Office use only:

MR#:_____

Driver's License:_____

Date Received:_____

Tech Initials:_____

Notified Billing:_____

The _____ vials of cryopreserved semen belonging to _____ were disposed according to the signed consent above. The semen specimens were removed from the storage tank location _____ on_____ and disposed of in the biohazard container per the hospital policy.

_____ _____

Lab Technician Verifying Lab Technician

Revised 7/19/2018 MD