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

CONSENT TO DONATE FROZEN SPERM

I, _____, _____, hereby declare
(Name) (Date of Birth)
my intent to donate all of my frozen, stored sperm to Strong Fertility Center (SFC) at the University of Rochester. I understand that as of the date below, I will no longer have access to my frozen sperm or be responsible for paying any storage fees. My sperm will only be used for training and quality control purposes and then discarded according to standard laboratory protocol. It will NOT be used to create a pregnancy.

Patient Signature: _____ Date: _____

Notary Public: _____ Date: _____

OR

SFC Witness: _____ Date: _____

Witness Printed Name/Title: _____