



Columbia University 5 Columbus Circle PH Floor New York NY 10019

P: 212-314-8825 Fax: 212-314-8801 Email: fertility-lab@cumc.columbia.edu

Consent For Sperm Disposition

Dear Patient,

See below for the consent for SPERM disposition. Please read the statements carefully and select one of the options. Be sure to keep a copy for your record.

Disposition forms that are incomplete or contain errors will be considered invalid and new disposition consents will be issued (storage fees will apply until the consenting process is complete and approved).

For EMBRYO Disposition, please email request to fertility-lab@cumc.columbia.edu

Thank you,

Laboratory Team

Please mail completed form to:

Attn: Andrology Lab@ Columbia University
5 Columbus Circle PH
New York, New York 10019
See email and fax info above.



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Consent For Sperm Disposition

I, _____ no longer wish to continue storage of my
Print Full Name

cryopreserved sperm sample (s) at Columbia University. I authorize Columbia University laboratory staff to remove the sperm sample(s) from cryogenic storage for discard in my absence. I understand that all of my stored frozen sperm will be destroyed and will no longer be available for use. I understand that this consent must be signed and witnessed by a notary.

I would like to (*check one option*):

☐ Discard all of my cryopreserved **ANONYMOUS/DIRECTED DONOR** sperm sample(s)
Must be completed and signed by FEMALE PATIENT only.

☐ Discard all of my cryopreserved **CLIENT DEPOSITOR** sperm sample(s)
Must be completed and signed by MALE PARTNER only.

Patient Print Name: _____ DOB: _____

Signature: _____ Date: _____
*Date must match notary date

NOTARY State of _____ County of _____

On this _____ day of _____, 20____, before me personally
appeared _____ known to me (or satisfactorily proven) to be the person who
executed the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

Notary Public

CUFC Personnel use only

Witnessed by: Print Name _____ Date: _____

Identification Used _____ Expiration Date _____

Tissue Bank Director: _____ Date: _____