**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY, L.L.C.**
2323 Whittlesey Road
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# CONSENT TO DISPOSE OF CRYOPRESERVED SPERM

Patient's Name: _____ DOB: _____

Spouse's Name: _____ DOB: _____

I (we) currently have cryopreserved sperm stored at the Columbus Center for Reproductive Endocrinology & Infertility.

I (we) now wish to have all cryopreserved sperm disposed of according to the laboratory protocol.

We understand that the alternative option is continued storage, which I (we) do not wish do to.

I (we) voluntarily consent to have my (our) sperm disposed of.

_____ _____
Patient's Signature Date

_____ _____
Spouse's Signature Date

_____ _____
Witness' Signature Date

_____ _____
Physician's Signature Date