ATLANTIC ASSISTED REPRODUCTIVE THERAPIES

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CONSENT FOR THAWING FROZEN SPERM

I, _____________________________________, of ____
(name: LAST, First) (address and telephone)

____ am requesting that AART thaw my cryopreserved sperm samples as described below.

I agree that:

1. I am the owner of the sperm samples.
2. The sperm samples may ***only*** be thawed and used for Assisted Reproductive Technology (ART) treatment for my partner: _______________________________________ .
(Name: LAST, First)
3. The AART laboratory scientists will determine how many straws of sperm to thaw and which sample to thaw should there be more than one banked specimen.
4. I acknowledge that all straws may have to be thawed to obtain the best possible sperm sample for ART treatment.
5. I will not hold the physician, AART, or any of its employees responsible for the failure of the sperm to survive freezing and thawing.
6. This consent is only valid for the time between the dates indicated below. Should a change in the dates be required, a new consent must be completed.
7. The consent to thaw sperm may be revoked at any time but such a request must be made in writing to AART and must contain my original signature.
8. This consent does not replace any portion of the original **Sperm Banking Agreement**, signed by me at the time of sample production and cryopreservation.
9. Additional fees might be charged for thawing and preparing banked sperm for use.

Time period for which this consent is valid:

From: the __________ day of _______________ , 200__

To: the __________ day of _______________ , 200__

_________________________________ (client signature)

_________________________________ (client name – please print)

_________________________________ (witness signature)

_________________________________ (witness name – please print)

Dated at _____________, _____________________, this ___________ day of ________________, 200__
(Location) (Province)