Northwestern Fertility and Reproductive Medicine
259 E. Erie Suite 2400 ♦ Chicago, IL 60611
Telephone (312) 695-1364 Fax (312) 472-0226
Email to Attn: Sofie at FRMMedRecs@nm.org

Semen Disposition Consent Form

I _____authorize that **all** of my sperm specimen(s) deposited
(Please print full name)
at the cryo-storage facility of Northwestern Medical Faculty Foundation to be disposed as marked below.

Please initial one of the following two choices:

_____ Continue storage for another twelve months from original receive date and agree to pay $400.00

Payment method:

By check#_____ or by Credit Card (call me for CC info@ _____)

Patient signature: _____ Date: _____

For identification purposes: Last four# of SSN: _____ DOB: _____

OR

_____ to be DISCARDED and I will not hold NMFF and its employees liable for the loss of the specimen.

**In order for this option to be valid – it must be notarized below

Patient signature: _____ Date: _____

For identification purposes: Last four# of SSN: _____ DOB: _____

To be completed by Notary Public

Print Name: _____

Signature: _____

City & State: _____

Date: _____

Notary Seal

Received at NFRM on _____ by_____