55 Francisco Street, Suite 500
San Francisco, CA 94133

REQUEST FOR DISPOSITION OF CRYOPRESERVED SPERM

NOTICE: THE OWNER OF THE SAMPLE MUST PROVIDE A PHOTO ID (see Note below)

Date ________________________

Patient PTR ID: ____________ (for office use only)

Patient Name: ____

Date of Birth: _____/_____/_____ (mm/dd/yy)

Dear Patient:

This form is provided for you to give us instructions regarding disposition of you frozen sperm.

Please note that unless donor sperm was used, the *male partner* whose sperm is stored needs to sign this form.

If you need further information or have any questions, please call our office at (415) 249-3636.

Discard my frozen sperm. I understand that all sperm stored in my name will be thawed and disposed of in accordance with professional, moral, and ethical standards and applicable legal requirements.

________________________________ ________________________________

Signature Print name

________________________________ ________________________________

Notary (please stamp or attach acknowledgement)
Or
PFC Employee (please attach copy of photo ID)

Print name

NOTE: To have sperm discarded, you must include a copy of your driver's license, passport, or other photo ID to verify your signature.