CONSENT TO DISCARD FROZEN STORED SPERM

I, _____, _____,
(Name) *(Date of Birth)*

hereby authorize Strong Fertility Center (SFC) at the University of Rochester Medical Center to discard all of my stored frozen sperm.

Patient's Signature: _____ Date: _____

SFC Witness Name: _____

SFC Witness Signature: _____ Date: _____

OR

Notary: _____ Date: _____

SFC USE ONLY	
MRN #	
Date Rec'd.	
Witnessed/Notarized	
Billing Notified	
Tech Initials	

STRONG FERTILITY CENTER
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