Northwestern Medicine®
Fertility and Reproductive Medicine

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OFFICE: 847.535.8700 **FAX**: 847.535.6999

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 Group 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 NMG 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 FRM on _____ by_____