HEARTLAND
FERTILITY

Patient Name _____

PHIN or Date of Birth_____

DISPOSAL OF CRYOPRESERVED SPERM

I the undersigned hereby consent to the disposal of my cryopreserved sperm in storage at the Heartland Fertility & Gynecology Clinic.

I acknowledge that my consent has been given voluntarily and the consequences have been fully explained to my satisfaction.

DATED this _____ day of _____ , 20_____ .

_____
SIGNATURE

_____
PRINTED NAME

_____
WITNESS

_____
PRINTED NAME

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