Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912) 352-8588 ● (912) 352-8893 FAX

CONSENT TO DISPOSE OF PATIENT CRYOPRESERVED
SPERM SPECIMEN(S)

I, ____ am requesting the Andrology Lab at Georgia Center for Reproductive Medicine dispose of my cryopreserved sperm specimen(s) that is/are being held in storage.

______________________________________ ____________________
Patient's Signature Date

____
SSN

______________________________________ appeared before me on the ______ day of _____________________, 20___ and signed this document as his/her voluntary act and deed.

____
Notary Public

My commission expires:_________________