Reproductive Health Associates, INC.
Reproductive Endocrinology and Infertility
Andrology and Gynecology
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Authorization to Destroy Semen Specimen

This signed, dated and notarized destruction authorization must be received by Reproductive Health Associates, INC. to complete your request.

We recommend returning this form via USPS Certified Mail to ensure that it arrives at its intended destination of Reproductive Health Associates, INC.

The purpose of this Authorization is to document the Patient's permission and authorization for the permanent and irretrievable destruction of stored semen specimens.

I, _____ want all of the semen specimens stored by Reproductive Health Associates, INC. destroyed. Destruction of the semen specimens means the semen specimens are thawed with no further action, which will result in their permanent and irretrievable destruction.

I assert that I have the authority to destroy the semen specimens because:

Choose only one below:

____ I produced the semen (thus I am a client depositor/directed donor) and I want them all destroyed.

____ I own the donor semen specimens and want them destroyed.

Donor#: _____ # Vials: _____ Lot#: _____

I fully understand that my destruction request is irrevocable and final the day the form is received by Reproductive Health Associates, INC. The semen specimens will be permanently and forever destroyed.

This agreement supersedes and takes precedence over any other disposition document signed by me, including agreement to treatment documents prepared by the physician or clinic providing assisted reproduction medical services or storage facilities, including any Storage Agreement with Reproductive Health Associates, INC. currently on file with Reproductive Health Associates, INC.

By signing this document and returning it to Reproductive Health Associates, INC. I authorize Reproductive Health Associates, INC. to destroy all vials of my semen specimens presently in storage at Reproductive Health Associates, INC.

Name: _____ Acct: _____Phone:_____

Address: _____

City: _____ State: _____ Zip code: _____

Signature: _____ Date: _____

Information below to be completed by Notary:

State of: _____ County of: _____

The foregoing instrument was acknowledged before me, this day of _____, 20_____ by

_____ _____

Name of Patient Notary Public

My commission expires: _____ Seal: