FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G.
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

CONSENT TO DONATE SPERM TO DESIGNATED RECIPIENT

1. Names of parties

I, _____, of _____ County, City of_____ in the state of _____ am over the age of twenty-one (21) years. I voluntarily offer to donate my sperm to the following designated recipient individual or couple for reproductive purpose.

_____
Name of recipient individual Date of Birth

_____
Name of intimate partner of recipient individual Date of Birth

_____
Address State Zip Code

_____
Home phone Cell phone Work phone

2. Nature of authorization
(Check ONE appropriate box and initial next to that box)

☐ _____I give my consent and authorize the designated recipient individual or couple to use the donated sperm strictly for her/their reproductive use only. After the designated recipient individual or couple complete or terminate treatment to achieve a pregnancy or pregnancies, all remaining vials of donated sperm will be discarded and destroyed **without further notice to me**.

☐ _____I give my consent and authorize the designated recipient individual or couple to have unrestricted use of the donated sperm. I relinquish all rights of ownership including the right of decision-making regarding the use, transfer of ownership and other disposition of the donated sperm. I understand and accept that this may mean upon completion or termination of treatment to achieve a pregnancy or pregnancies by the designated recipient individual or couple, the remaining vials of sperm may be donated to other individual(s) for reproductive purpose, donated for research purpose such as laboratory quality control or scientific studies, or discarded and destroyed.

3. Screening tests for sperm donor

For the purpose of determining whether I am an acceptable sperm donor, I consent to a detailed medical history, a physical examination, a semen analysis and laboratory testing of my blood and urine for drug use and sexually transmitted diseases as required by the
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Food and Drug Administration (FDA) under federal law (21 CFR 1271 Human Cells, Tissues, and Cellular and Tissue Based Products HCT/P). These tests include testing for human immunodeficiency virus (HIV), human T-lymphotropic virus (HTLV), hepatitis B, hepatitis C, syphilis, gonorrhea, chlamydia, and cytomegalovirus (CMV) infection.

To the best of my knowledge: **(Check EACH box, initial next to each box and fill in the blank for any exception that applies**)

☐_____ I am in good health; I have no communicable disease; and I do not now, nor have I ever suffered from any physical or mental illness, diagnosed with any medical disease or condition, mental impairment or disability, except as follows:

_____
_____

☐_____I am not now, nor have I ever been afflicted with human immunodeficiency viruses (HIV), hepatitis C, hepatitis B, syphilis, gonorrhea, chlamydia, genital herpes, condyloma or any other venereal disease, except as follows:

_____
_____

☐_____I am not now, nor have I ever engaged in behavior recognized to be risk factors for human immunodeficiency virus (HIV) infection. These include but not limited to blood transfusion prior to 1985, prostitution, intravenous drug use, sexual relationship with a partner or partner(s) known to be HIV infected or engaged in behavior generally recognized to be risk factors for HIV infection.

☐_____I am not now, nor have I ever had alcoholism, drug addiction, or intravenous drug abuse, except as follows:

_____
_____

☐_____None of my grandparents, parents, brothers, sisters, or children, if any, nor their lineal descendants, have ever been afflicted with emotional illness or any inherited mental or physical disabilities or disease, except as follows:

_____
_____

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4. Storage of frozen sperm

If I am determined to be an acceptable sperm donor, my semen samples will be processed and frozen according to standard freezing procedures. The frozen samples will then be

(check ONE appropriate box and initial next to that box)

☐_____stored on site at the Family Fertility Center (FFC)

☐_____shipped to another facility for storage. I understand and accept that it my responsibility to arrange with the designated recipient individual or couple for the shipping of all cryopreserved specimens to the designated treatment facility. I am solely responsible to execute all necessary documents from the receiving facility expeditiously. I shall send copies of such documents to the FFC so the transfer can be completed. Any and all fees associated with this request must be paid prior to shipping.

until such time in the near future when the recipient individual or couple will begin treatment using my frozen samples.

I understand that, with any technique necessitating mechanical support systems, equipment failure can occur. Dr. H. Christina Lee, the Family Fertility Center, and its staff are not to be held liable for any destruction or damage to the frozen sperm caused by or resulting from any malfunction of equipment, failure of utilities, fire, wind, earthquake, water, or other acts of God.

5. Parental rights and duties

The designated individual or couple will be the intended and legal parent(s) of any and all child(ren) born as a result of the use of these donated sperm. I accept and agree that I will have neither the rights nor the duties of a parent to any offspring born as a result of my sperm donation. I, myself, and my heirs, agents, and assigns, relinquish any claim of paternal rights to any offspring borne as a result of my donated sperm. This includes but not limited to decision making, such as termination of a pregnancy, in the event a pregnancy results from the use of the donated sperm.

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6. Legal concerns

Statutes and case law vary among different states and countries with respect to the legal rights and duties of a sperm donor. You are strongly advised to consult with an attorney to further clarify any and all of your legal concerns **before** you proceed.

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7. Acknowledgement

I hereby acknowledge that my decision to donate sperm to the above named designated recipient individual or couple is made freely and voluntarily. I understand insurance coverage for all or any part of this procedure may not be available and accept my personal responsibilities for payment of all costs of this procedure, including laboratory charges and physician's professional fees, as well as costs incurred as a result of any complication which may occur.

I have the opportunity to read and ask questions about the entire process of sperm donation and the contents of this document. I understand the information provided and my questions have been answered to my satisfaction. I execute this consent form freely and voluntarily. I have not relied on any inducements, promises, or representations made by Dr. H. Christina Lee, the Family Fertility Center or its staff. I hereby agree that absent an order by a court of law, this agreement and authorization shall be binding and irrevocable.

_____

Name of sperm donor Signature Date

***Please photocopy of both sides of driver's license for identification purposes.**

State of_____

County of_____

Sworn and subscribed to before me,

Date_____**20**_____

_____

Signature & Seal of Notary Public

State of_____

My commission expires_____

Initials _____