

DUKE FERTILITY CENTER

REQUEST TO **DISCARD** FROZEN SEMEN

I _____, Duke Medical Record Number _____, request that the cryopreserved semen specimens collected and stored in my name be **removed from storage at Duke Fertility Center and discarded.**

This request applies to the following specimen(s):

DISCARD	The following VIALS OF SPERM:
Date(s) Frozen:	Vial Number(s):

Please list the best two phone numbers where you can be reached if there are any questions. Thank you!

PLEASE NOTE: Your signature at the bottom of this document must EITHER be signed in the presence of a Notary Public OR be witnessed by a member of the Duke Fertility Center Laboratory Staff.

State of _____
_____ County

Sworn to and subscribed before me
this the ____ day of _____, 20____.

Notary Public

Witnessed By:

(Duke Fertility Center Lab Staff Only)

(Print)

(Date)

Name (print)

Signature

Date