University Women's Healthcare-Fertility Center
401 E. Chestnut, Ste. 410 – Louisville, KY 40202
Tel. 502-271-5846; Fax 502-271-5984

TRANSFER OF CRYOPRESERVED SPECIMEN TO PATIENT'S CARE

ACKNOWLEDGMENT & RELEASE

THIS ACKNOWLEDGMENT & RELEASE, entered into this _____ day of _____, 20_____

By _____

& _____ ("Releasers"),
in favor of University OB/GYN Associates, P.S.C.

The Releasers request that University OB/GYN Associates, P.S.C.
transfer their cryopreserved _____(Please Specify)
currently being stored in liquid nitrogen at the Fertility Center to the Releasers care for the purpose of transporting to another fertility program.

The Releasers expressly release University OB/GYN Associates, P.S.C. it's employees and agents, from any and all liability for all claims and demands Releasers now have or may thereafter have for injury or damage arising from the transfer of the cryopreserved specimen from University OB/GYN Associates, P.S.C. to the Releasers' care for purposes of transporting to another fertility program and/or improper thawing of this tissue.

IN WITNESS WHEREOF, the Releasers have executed this Consent & Release on the date, month and year first written above.

_____
Signature of Releaser Date

_____
Signature of Releaser Date

_____
Signature of Witness (Fertility Center Staff or Notary)

Our current contact info is:

Telephone _____
Address _____
_____
_____

Please return original to: Embryology Laboratory - Fertility Center
401 East Chestnut Street - Suite 410
Louisville, KY 40202

Attention: Signatures must be witnessed by Fertility Center Staff or a Notary for the form to be valid