

Statement of Understanding for Intended Parent(s)/Recipient(s) Using Directed Donor Sperm

CryoGam Colorado, LLC 2216 Hoffman Dr., Unit B Loveland, CO 80538 800-473-9601

This form is to be signed by the Intended Parent(s)/Recipient prior to the completion of directed donor screening, testing and cryopreservation.

Donor Name: _____ **Donor DOB:** _____

Primary Intended Parent/Recipient: _____ **DOB:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Alternate Phone:** _____ **Email:** _____

Additional Intended Parent/Recipient (if applicable): _____ **DOB:** _____

Phone: _____ **Alternate Phone:** _____ **Email:** _____

Recipient's Physician: _____ **Phone:** _____

Address: _____ **Fax:** _____

_____ **Email:** _____

Please read the following statements of understanding regarding the use of directed donor sperm processed by CryoGam.

1. I understand that all fees are non-refundable and are due at the time of service regardless of the specimen quality, test results, donor eligibility or specimen use. I understand that if the directed donor does not complete the screening, testing, and release process according to CryoGam's requirements, no fees will be reimbursed and specimens will not be eligible for release.
2. I understand that any financial contribution by Intended Parent(s)/Recipient(s) does not entitle nor ensure access to the directed donor's health information or cryopreserved sperm specimens. I understand that regardless of which party pays for the services, the directed donor may withdraw his permission for use of the cryopreserved sperm at any time.
3. I understand that CryoGam's satellite offices have limited appointment times. I understand that the directed donor may have to travel to the Loveland office in order to complete parts of the directed donor program. I understand that it is the responsibility of the directed donor and/or the Intended Parent(s)/Recipient(s) to call and cancel scheduled appointments within 24 hours of the appointment or I may be charged a \$50.00 cancellation fee.
4. I understand that the directed donor must authorize CryoGam to release and discuss medical information with Intended Parent(s)/Recipient(s). I understand that the release of information can be revoked by the donor at any time.
5. I understand that the directed donor must provide written authorization for the Intended Parent(s)/Recipient(s) to use his cryopreserved sperm for artificial reproductive procedures. I understand that the directed donor has the right to retain full control over the release of his specimens.

