

DATE EFFECTIVE: 06/01/10	<b>International Identity (ID) Option Patient Agreement</b>	FORM: ACQ. 20ao REV: <b>B</b>
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**3015 Williams Drive, Ste 110, Fairfax, VA 22031 USA Phone: 800-338-8407 Fax: 703-698-3933**

Shaded boxes ( ) must be filled in.

I, hereafter known as recipient, and partner (if applicable) understand and agree that I have chosen a donor that is part of the Identity (ID) Options program at Fairfax Cryobank or Cryogenic Laboratories, Inc., (hereafter known as Cryobank) and is distributed by

Company Name **CAN-AM Cryoservices**

Address: **1057 Main St. W. Suite 102**

City: **Hamilton** State/Province **Ontario** PostalCode: **L8S 1B7**

Phone: **1-888-245-3471** Fax: **(905) 524-3935**

My Donor # is . By using an ID Options donor I can choose to participate fully, by registering my child conceived by this donor ("Offspring") after birth and therefore allowing my offspring the option to access donor identifying information when they reach 18 OR I can choose to use this same donor as an anonymous donor, where I would not register the offspring after birth and he or she would therefore not be entitled to any access of donor identifying information when they reach the age of 18. When a registered offspring reaches the age of 18, this offspring will, if requested by him or her, be given access to the Donor's full name, date of birth, last known telephone numbers and addresses, and other personally identifying information that the Donor has agreed to release and that Cryobank in its sole and absolute discretion chooses to release ("Identifying Information"). I understand and agree to the following conditions:

I understand that I must sign and return this agreement and release form to Cryobank or our distributor before Cryobank or our distributor will ship units of semen from the Donor to be used for my insemination. This agreement is a separate document from the Identity (ID) Options Birth Registration form and must be signed regardless of my intent to submit a registration form after the birth of a child.

- 1) If I desire that my offspring have access to the donor identifying information when they reach the age of 18, I agree to promptly return to Cryobank or our distributor the required registration form, the ID Options Birth Registration form, which can be obtained from Cryobank's websites, [www.fairfaxcryobank.com](http://www.fairfaxcryobank.com) or [www.cryolab.com](http://www.cryolab.com) for each such Offspring upon birth. Merely using semen from the Donor does not allow any Offspring access to the Identifying Information.
- 2) I understand and agree that the Registered Offspring will be the only individual(s) with the authority to request Identifying Information and to have access to the Identifying Information. I understand and agree that under no circumstances will Cryobank release any Identifying Information until any Registered Offspring has reached 18 years of age, nor will it release any information to me. I acknowledge and agree that the Identifying Information is for the exclusive use of the Registered Offspring. I agree that I will, and will cause any Registered Offspring to hold and keep the Identifying Information in strict confidence, not publish, publicize or sell the Identifying Information, and not disclose the Identifying Information to any other person or entity. I acknowledge and agree that any violation of this provision would cause immediate and irrevocable harm to the donor and would be the basis for obtaining an immediate injunction.
- 3) I and my partner (if we are married) will be named on the birth certificate of any child born using this semen donation. I understand and agree that Donor will have no legal relationship, rights or obligations to any child born using donated semen.
- 4) I acknowledge and agree that Cryobank is not responsible for locating, updating, or otherwise obtaining new Identifying Information about the Donor, but rather Cryobank's obligation is to release the Identifying Information that is in Cryobank's possession to the Registered Offspring. There may be a situation where a contact between the donor and offspring cannot be established, despite Cryobank's best efforts.

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I, on behalf of myself and any Offspring, hereby irrevocably and unconditionally agree to release and discharge Cryobank and its past, present, or future directors, employees, affiliates and distributors, and the donor from any and all claims, actions, liabilities, charges, costs, demands, debts, obligations, and expenses (including reasonable attorneys' fees and legal expenses) of any nature that I or any of our Offspring, heirs, or assigns now has, ever has had, or may in the future have. I hereby agree that I shall, and shall cause my Offspring, heirs or assign to refrain from bringing any legal or equitable action against Cryobank or the Cryobank. Affiliates/Distributors for any reason in any way related to the Identity (ID) Options Program including, without limitation, if future attempts to locate the Donor are unsuccessful or if the Donor is unwilling to communicate with the Offspring, if Cryobank is in any way legally prevented from disclosing Identifying Information to the Offspring or any constitutions, statues, rules, regulations, administrative or judicial orders, or similar laws or legal requirements prevent Cryobank from releasing Identifying Information.

This agreement shall be binding upon myself and my Offspring, assigns, heirs, executors and administrators. This represents the entire agreement between the parties concerning the subject matter; and there are no understandings, agreements, or representations other than as herein set forth. The agreement shall be binding upon the parties and their respective assignees, heirs, executors, and administrators. This agreement shall be construed in accordance with the laws of the State of Virginia, USA.

In Witness Whereof, I have executed this document for Identity (ID) Option Agreement privileges for Donor # \_\_\_\_\_,

This agreement is entered into between Cryobank and the recipient and/or recipient partner on this

\_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_.

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Signature of Recipient Partner (if applicable)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State/Province, ZIP/Postal Code

\_\_\_\_\_  
City, State/Province, ZIP/Postal Code

\_\_\_\_\_  
Country

\_\_\_\_\_  
Country

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Daytime Phone Number

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City, State/Province of \_\_\_\_\_

City, State/Province of \_\_\_\_\_

Country of \_\_\_\_\_

Country of \_\_\_\_\_

The foregoing instrument was subscribed and acknowledged

The foregoing instrument was subscribed and acknowledged

before me this \_\_\_\_ day of \_\_\_\_\_,

before me this \_\_\_\_ day of \_\_\_\_\_,

2\_\_ by \_\_\_\_\_.  
(Recipient)

2\_\_ by \_\_\_\_\_.  
(Recipient Partner)

**Please have a physician/clinic representative or a notary public complete this section of the agreement**

\_\_\_\_\_  
Physician/Clinic Representative      Date

\_\_\_\_\_  
Physician/Clinic Representative      Date

Representative Title: \_\_\_\_\_

Representative Title: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

OR

OR

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

SEAL

SEAL

\_\_\_\_\_  
Cryobank Representative Signature      Date

PLEASE MAIL SIGNED, WITNESSED FORM TO:  
**Attn: Identity (ID) Option Patient Agreement**  
**CAN-AM Cryoservices**  
**1057 Main St. W. Suite 102**  
**Hamilton, ON L8S 1B7**

Copies with Cryobank signature are available by contacting our distributor  
Name: CAN-AM Cryoservices  
Phone: 1-888-245-3471  
Email: info@canamcryo.com