CAN-AM CRYOSERVICES
DONOR EGG & SPERM BANK

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CONSENT FOR THE RELEASE AND TRANSFER OF HRM OR EMBRYOS

CLIENT DEPOSITOR INFORMATION

_____ Date of Birth _____/_____/_____
Client Depositor Name (LAST, First, Initial) *YYYY MM DD*

_____ Date of Birth _____/_____/_____
2nd Client Depositor Name (LAST, First, Initial) *YYYY MM DD*
(IF APPLICABLE – Embryos only)

FACILITY TO RECEIVE TRANSFER

_____
Name of Clinic, Hospital or Physician's Office

_____ _____ _____ _____
Street № & Name *City* *Prov.* *Postal Code*

Telephone: Home: (_____)_____ FAX: (_____)_____

MATERIAL TO BE TRANSFERRED:

☐ Sperm ☐ Egg(s) ☐ Embryo(s) ☐ Other: _____

Indentifying Information

Collection Date(s)	Specimen Number(s)	Other Information	Number of Containers

Date requested for transfer: _____/_____/_____
YYYY MM DD

I/We authorize CAN-AM Cryoservices to transfer the HRM and/or Embryo(s) identified above to the facility or physician indicated for use in accordance with my/our consent and applicable Regulations.

I/We understand that use of HRM or Embryo(s) is limited to my/ourselves and/or to my spouse or common-law partner at the time of use.

X *Sign Here* _____ _____
Signature of Client Depositor *Witness (Name)*

_____ _____
Signature of 2nd Client Depositor (IF APPLICABLE – Embryos only) *Witness (Signature)*

Dated this _____ day of _____ , 20_____