EMORY
REPRODUCTIVE CENTER
*550 Peachtree St. Suite 1800, Atlanta GA 30308*
*(404) 778-3401 FAX (404) 686 4501 CLIA ID 11D0897047*

**Place Patient Sticker Here*

Name: _____
MRN: _____
DOB: _____

# AUTHORIZATION FOR SHIPMENT OF FROZEN TISSUE TO FLORIDA REPROTECH

We, _____
PATIENT NAME PATIENT DATE OF BIRTH

and _____,
PARTNER NAME (if applicable) PARTNER DATE OF BIRTH

hereby authorize and instruct the Emory Reproductive Center of the Emory Clinic, Inc. to remove all of my/our remaining frozen tissue from storage for transport to:

**Reprotech Florida (Long Term Storage)**
**4661 Johnson Rd., Suite 2 Coconut Creek, FL 33073**
**PH# 954-570-7687**

I/we understand that there are material risks to frozen tissue (sperm, eggs, and embryos) during transport which could result in the damage or loss of sperm, egg, or embryo viability. I/we accept all responsibility for any losses or damage to the sperm, eggs, or embryos as a result of our desire to have the frozen eggs, sperm, or embryos moved. I/we agree to absolve, release, indemnity, protect and hold harmless the Emory Reproductive Center, Emory Clinic, Inc., its officers, directors, agents and employees from any and all liability associated with the handling and transport of our frozen embryos to the above designated facility. I/we allow Reprotech to contact me/us regarding our frozen eggs, sperm, and/or embryos.

On signing this form, I/we acknowledge that I/we have read the above statement regarding the release of my/our frozen eggs, sperm, and/or embryos, and I/we wish to take full responsibility for the release.

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| PATIENT SIGNATURE | **REPROTECH ID #** | DATE | TIME |
| PARTNER SIGNATURE (if applicable) | **REPROTECH ID #** | DATE | TIME |

**Instructions to Patients**

In order for this consent for shipment of the tissue to be acceptable, we must receive a copy of the form from the Patient and Partner. This form can be sent via patient portal or completed in person at the Emory Reproductive Center.