



**UNIVERSITY HOSPITALS FERTILITY CENTER**  
A service of University Hospitals Cleveland Medical Center

**AUTHORIZATION TO DISCARD FROZEN SPECIMEN**

I/We, \_\_\_\_\_ [Printed Name(s)]  
(individually and collectively, the “Patient”), release all of my/our frozen embryos (the  
“Specimen”) currently cryopreserved at UH Fertility Center and authorize for UH Fertility Center  
to discard the Specimen in accordance with the practice standards of the American Association of  
Tissue Banks and all applicable local, state, and federal laws.

**Patient – Spouse or Partner 1**

Signature: \_\_\_\_\_ Address: \_\_\_\_\_  
Print: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Patient – Spouse or Partner 2**

Signature: \_\_\_\_\_ Address: \_\_\_\_\_  
Print: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone: \_\_\_\_\_