Seattle Sperm Bank

INFORMED CONSENT FOR DONOR 12195 (KAYDEN) SEMEN USE

_____ ("Patient to be inseminated") hereby acknowledge and represent as follows:

_____ _____ The undersigned patient seeks to use donated semen from Donor 12195 (Kayden) collected by the Seattle Sperm Bank for reproductive use.

_____ _____ Patient understands that donor has tested positive as a carrier of 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia.

_____ _____ Patient is aware of the aforementioned exceptions and genetic disease risks associated with each.

_____ _____ Patient agrees to personally assume all risks associated with Patient's use of semen samples donated by a Donor that has tested positive as a carrier of 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia. Patient hereby releases Seattle Sperm Bank and its current and former officers, directors, employees, attorneys, insurers, agents and representatives of any liability or responsibility whatsoever for any and all outcomes, whether currently known, suspected, unknown or unsuspected, arising out of Patient's use of donor semen donated by Donor that has tested positive as a carrier of 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia.

Please input your initials as the patient in ONE of the following boxes.

	I understand the risks associated with using donor semen donated by Donor 12195 Kayden that has tested positive as a carrier of 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia, and I have been offered genetic testing for this condition by Seattle Sperm Bank and I am choosing to **DECLINE** testing on myself for this condition.
	I understand the risks associated with using donor semen donated by Donor 12195 Kayden that has tested positive as a carrier of 21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia, and I have been offered genetic testing for this condition and have chosen to have myself screened for this condition, as facilitated by Seattle Sperm Bank through the use of Counsyl genetic testing.

_____ _____

Date Patient's Signature

_____ _____

Date Patient Partner's Signature (if applicable)