Informed Consent For Donor 12847 Daulton

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

Patient Initials — The undersigned patient seeks to use donated semen from **Donor 12847 (Daulton)** collected by the Seattle Sperm Bank for reproductive use.

Patient Initials — Patient understands that donor has tested positive as a carrier of *Deafness-Autosomal Recessive 8/10, Metachromatic Leukodystrophy and Polyglandular Autoimmune Syndrome Type 1.*

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

Patient Initials — 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 *Deafness-Autosomal Recessive 8/10, Metachromatic Leukodystrophy and Polyglandular Autoimmune Syndrome Type 1*. 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 *Deafness-Autosomal Recessive 8/10, Metachromatic Leukodystrophy and Polyglandular Autoimmune Syndrome Type 1*.

Please select ONE of the following boxes:

☐ **I DECLINE Testing**

I understand the risks associated with using donor semen donated by *Donor 12847 (Daulton)* that has tested positive as a carrier of *Deafness-Autosomal Recessive 8/10, Metachromatic Leukodystrophy and Polyglandular Autoimmune Syndrome Type 1*, 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 ACCEPT Testing**

I understand the risks associated with using donor semen donated by *Donor 12847 (Daulton)* that has tested positive as a carrier of *Deafness-Autosomal Recessive 8/10, Metachromatic Leukodystrophy and Polyglandular Autoimmune Syndrome Type 1*, 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 genetic testing.

Partner or Spouse Name (if applicable):

X _____ X Angelo Allard

Signed By Seattle Sperm Bank

verified by approveme

Signed On: February 21, 2024

Signature Certificate

Document name: Informed Consent For Donor 12847 Daulton

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LEGALLY SIGNED USING WPesignature
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Timestamp	Audit
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This audit trail report provides a detailed record of the online activity and events recorded for this contract.