

DATE EFFECTIVE: 06/06/11	<b>Fairfax Cryobank Patient Photo Agreement and Order Form</b>	FORM: ACQ.20t REV: K
--------------------------	----------------------------------------------------------------	-------------------------

**Instructions:**

1. Read this agreement carefully and if you agree with these terms, please sign as indicated.
2. Complete the order information, including payment information. Indicate the type of photo set(s) you are ordering and the donor number(s). **A separate signed agreement is required for each donor selected (pages 1 and 2).** However, several photo sets may be ordered together on the same order form (page 3). You may make copies of an unsigned Agreement as needed for additional donors selected.
3. You may mail, scan and email, fax or FedEx for weekday delivery the original signed agreement(s) (pages 1 and 2) and order form (page 3) to the address, fax or email listed on the final page of this document.
4. The order will be processed upon arrival and you can expect the photo set(s) to arrive by mail, FedEx (if you select this option), or email shortly thereafter. We will contact you by phone only if there are questions regarding your order.

**PATIENT PHOTO AGREEMENT**

I, hereafter known as recipient and partner if applicable understand and agree that we have chosen to participate in the Donor Photo Program of the Fairfax Cryobank (hereinafter Cryobank) for Donor # \_\_\_\_\_ (“Donor”). We understand and agree to the following conditions:

1. I understand and agree that I must sign and return this agreement and release form to Cryobank before Cryobank will send photograph(s) of the donor. If I am requesting photographs on multiple donors, I understand I must sign and return a separate agreement and release form for each donor (pages 1 and 2).
2. I agree on behalf of myself, partner (if applicable) and any Offspring, hereby irrevocably and unconditionally release and discharge Cryobank and its past, present, or future directors, employees, and affiliates, and the donor from any and all claims, actions, liabilities, charges, costs, demands, debts, obligations, and expenses (including reasonable attorneys’ fees and legal expenses) of any nature that I or any of my Offspring, heirs or assigns now has, ever has had, or may in the future have related to the Donor Photo Program. I hereby agree that I shall, and shall cause our Offspring, heirs or assigns to refrain from bringing any legal or equitable action against Cryobank or the Cryobanks’ Affiliates for any reason in any way related to the Donor Photo Program.
3. I agree on behalf of myself, partner (if applicable) and any Offspring, agree to keep anonymous the Donor photo(s) received from Cryobank and not publicize or otherwise publish the photos for any reason. I agree on behalf of myself, partner (if applicable) and any Offspring agree not to attempt to contact the Donor or attempt to discover the identity of the donor, including personal information about the Donor. I agree that I will, and will cause any Offspring to hold the photo(s) in strict confidence. I acknowledge that any attempts by me, my partner (if applicable) or Offspring to contact the Donor or publish the photos would cause immediate and irrevocable harm to the Donor and would be the basis for obtaining an immediate injunction.
4. I and my partner (if I am married) agree that I will be named on the birth certificate of any child born using a semen donation from the Donor. I understand and agree that the Donor will have no legal relationship, rights or obligations to any child born using his donated semen.

<b>DATE EFFECTIVE: 06/06/11</b>	<b>Fairfax Cryobank Patient Photo Agreement and Order Form</b>	<b>FORM: ACQ.20t REV: K</b>
---------------------------------	----------------------------------------------------------------	---------------------------------

5. This agreement shall be binding upon me, partner (if applicable) and my Offspring, assigns, heirs, executors and administrators. This represents the entire agreement between the parties concerning the subject matter; and there are no understandings, agreements, or representations other than as herein set forth. The agreement shall be binding upon the parties and their respective assignees, heirs, executors, and administrators. This agreement shall be construed in accordance with the laws of the State of Virginia, USA.

In Witness Whereof, I have executed this agreement and release form for Photo privileges on the Donor

#\_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Signature of Recipient Partner (if applicable)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Date Witnessed

\_\_\_\_\_  
Date Witnessed

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Signature

DATE EFFECTIVE: 06/06/11	<b>Fairfax Cryobank Patient Photo Agreement and Order Form</b>	<b>FORM: ACQ.20t REV: K</b>
--------------------------	----------------------------------------------------------------	---------------------------------

**DONOR PHOTO PROGRAMS  
ORDER FORM**

Donor # \_\_\_\_\_  
 \_\_\_\_\_Adult /Childhood Photo Set (\$45.00) or \_\_\_\_\_Lifetime Photo Series (\$75.00) (Check one)

Donor # \_\_\_\_\_ \_\_\_\_\_Adult /Childhood Photo Set (\$45.00) or \_\_\_\_\_Lifetime Photo Series (\$75.00)  
 (Check one)

Donor # \_\_\_\_\_  
 \_\_\_\_\_Adult /Childhood Photo Set (\$45.00) or \_\_\_\_\_Lifetime Photo Series (\$75.00) (Check one)

Shipping type (please select one):

- |                                            |           |
|--------------------------------------------|-----------|
| _____ Email                                | No Charge |
| _____ US Mail                              | No Charge |
| _____ Overnight Fed Ex weekday             | \$30.00   |
| _____ International Priority FedEx weekday | \$60.00   |

\_\_\_\_\_  
 Recipient Name

\_\_\_\_\_  
 Shipping Address

\_\_\_\_\_  
 City, State, ZIP

\_\_\_\_\_  
 Daytime Contact Number

\_\_\_\_\_  
 Email address

**Type of Payment:** Money Order or Cashier's Check enclosed (no personal checks accepted)

Credit Card: VISA      MASTERCARD      AMERICAN EXPRESS      DISCOVER

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Return signed original form to:

Fairfax Cryobank  
 Attn: Patient Photo Agreement  
 3015 Williams Dr. Suite 110  
 Fairfax, VA 22031  
 703-698-3933 (fax)  
[info@fairfaxcryobank.com](mailto:info@fairfaxcryobank.com) (email)