AMERICAN CryoStem
America's Stem Cell Bank℠

: 1-866-519-3554
: 732-747-7782
: support@americancryostem.com
: www.americancryostem.com

Authorization for Tissue Collection and Release of Liability

1. Acknowledgements

I, as the undersigned individual, acknowledge that I have given my informed consent to my physician to undergo liposuction or another surgical procedure, and that I also have given my informed consent to the collection of my fat tissue originating from the scheduled liposuction or other surgical procedure. I further acknowledge that my consent includes, but is not limited to; the performing of such procedures as may be necessary or appropriate to collect the fat tissue after removal by my physician, and to test and process the collected fat tissue to extract the Stromal Vascular Fraction (SVF), if any, that may be present in the fat tissue. I also acknowledge that I have entered into an agreement with American CryoStem Corp. for the transportation of my fat tissue to the laboratory for processing and retention of the SVF for storage, if any.

2. Authorization

As confirmed by my signature below, I hereby authorize and direct my physician and his/her employees and contracted health care provider(s) to collect fat tissue during my scheduled liposuction or other surgical procedure, for packaging, transport, delivery of the collected tissue to American CryoStem Corp. using a collection kit provided by American CryoStem Corp. I further understand that although the collection of the removed fat tissue is a relatively simple procedure, nonetheless complications may occur during the liposuction or surgical procedure that could preclude the collection of the fat tissue. Therefore, I agree that my physician may determine in the exercise of his/her professional medical judgment, whether or not to proceed with collecting the fat tissue during the procedure, and that the determination of my physician shall be final and binding on me.

3. Release from Liability

As confirmed by my signature below, I hereby fully and finally release, American CryoStem Corp., and each of its respective owners, directors, officers, employees, agents and affiliates, from any and all claims, liabilities, damages, costs, and expenses that I, or my heirs, assigns, or representatives may incur, resulting from or relating to the collection of (after removal by my physician), handling or processing of the fat tissue pursuant to my informed consent or this authorization.

4. Infectious Disease Statement

As confirmed by my signature below, I hereby fully attest that I either (a) do not have any infectious diseases or (b) I have/had an infectious disease and I have disclosed this information to American CryoStem Corp. prior to the procedure.

5. Excess Material Disposal

As confirmed by my signature below I hereby authorize American CryoStem Corp. to dispose of any excess material remaining following the completion of processing and creation of a full storage sample, with their sole discretion including disposal as medical waste, donations for academic or research purposes or any other purpose at American CryoStem Corp's discretion following all regulations as may be applicable.

6. Professional Fee

As confirmed by my signature below I understand that part of my total fee paid to American CryoStem will be paid to the physician for their service(s) and that American CryoStem is acting solely as a paying agent, acting on my behalf with regard to this payment.

Client: _____
(Printed Name)

Client: _____ Date: _____
(Client Signature)