AUTHORIZATION FOR RELEASE OF SEMEN

I am referring (patient's name) _____ to the European Sperm Bank USA, LLC. to obtain semen specimens for an assisted reproduction procedure.

I understand that every pregnancy has about 3 to 4% risk of producing a child with a birth defect or mental retardation. The life-time risk for all genetic disorders is higher. Genetic screening can reduce this risk to some extent, but it cannot eliminate the risk entirely.

My patient has agreed that all specimens obtained from the cryobank are for her personal use only.

The specimen type I wish to have provided to my patient is: (Please Check only one.)
Note: If no specimen type is selected, we will assume "Either ICI or IUI".

☐ I authorize her to obtain the specimens directly from the cryobank.

☐ ONLY specimens prepared for Intracervical Insemination (ICI). (Standard Process)

☐ ONLY specimens prepared for Intrauterine Insemination (IUI). (Pre-washed prior to freezing)

☐ Either ICI or IUI

Doctor's Signature*:_____

License Number:_____

Date Signed:_____

Print Name of Physician:_____

Hospital/Center Name:_____

Address:_____

City/State/Zip Code:_____

Telephone Number:_____Fax Number:_____

Please Keep a copy for your records.

* For residents of the state of NY, this form MUST be completed by the recipient's physician, physician assistant or nurse practitioner for all orders.

The above form(s) can either be faxed to our office fax number: (206) 588-1485 or emailed to info@europeanspermbankusa.com . You may also mail them to:

European Sperm Bank USA
4915 25th Avenue NE, Ste 204W
Seattle, WA 98105