AUTHORIZATION FOR RELEASE OF SEMEN

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

Licensed Medical Practitioner (LMP) to place initials or checkmark next to one of the options below. * For recipients undergoing treatment in the state of NY, this form MUST be completed by the recipient's physician, physician assistant or nurse practitioner for all orders.

_____This form authorizes the patient to receive the donor specimens directly; either through delivery to their home address or by picking it up from Seattle Sperm Bank and its affiliates.

_____This form authorizes the patient to transport shipments directly to our clinic address

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.

LMP Signature*:_____

License Number:_____

Date Signed:_____

Print Name of LMP:_____

Hospital/Center Name:_____

Address:_____

City/State/Zip Code:_____

Telephone Number:_____Fax Number:_____

Please Keep a copy for your records.

The above form(s) can either be faxed to our office fax number: (206) 466-4696 or emailed to forms@seattlespermbank.com. You may also mail them to:

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

Seattle Sperm Bank