AUTHORIZATION FOR RELEASE OF SEMEN
CLINIC DELIVERIES ONLY

This form authorizes the patient to transport shipments directly to our clinic address.

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

Licensed Medical Practitioner (LMP) to sign and complete entire form 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.

I/We 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.

The patient has agreed that all specimens obtained from the cryobank are for their 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

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