



# Clinical Release of Semen Form

Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

## Patient / Co-Parent Information

\_\_\_\_\_  
Patient Name (include middle name if applicable)

\_\_\_\_\_  
Partner/Spouse or Co-Parent Name (if applicable):

\_\_\_\_\_  
Patient Date of Birth (mm/dd/yyyy)

\_\_\_\_\_  
Partner/Spouse or Co-Parent Date of Birth (mm/dd/yyyy)

## Semen Specimen Type for Release

(Please select all that apply)

- Anonymous Donor IUI / Intrauterine Insemination Vials (Gradient washed; 0.5cc volume)
- Anonymous Donor ICI / Intracervical Insemination Vials (Unwashed; 1.0cc volume)
- Anonymous Donor IUI / ICI Vials: ART / IVF / ICSI Quality
- Directed Donor IUI Vials
- Directed Donor ICI Vials
- Sexually Intimate Partner IUI Vials
- Sexually Intimate Partner ICI Vials
- I Authorize waiving the recommended 6-month quarantine period for a Directed Donor

I am referring (Patient's Name) \_\_\_\_\_ to Cryobank America, to obtain semen specimens for an assisted reproductive procedure or for use in at-home insemination. I have informed the patient named above, of the risks and limitations of said patient's procedure and have authorized the patient to obtain the specimens from Cryobank America.

My patient understands that there are inherited risks and limitations of the patient's procedure, and that genetic or infectious disease screening can reduce this risk, but understands and acknowledges that the risk cannot be eliminated entirely. Additionally, the patient understands that by waiving the 6-month quarantine period it would subject them to inseminating potentially hazardous specimens as the testing may not show a new infection. This form is valid for two (2) years from date listed above.

## Authorization

My patient has agreed to the terms above and that all specimens obtained are for her personal use only.

Physician Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

License Number: \_\_\_\_\_ State Issued: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_

Contact Name: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**This document may be emailed, faxed, or mailed to our office once completed.**

Phone: (817) 945-8708 FAX: (817) 549-5179

E-Mail: info@cryobankamerica.com Subject: Clinical Release

Please keep a copy for your records

**Mailing Address:** Cryobank America (attn: Forms) 3050 S. Center St. Suite 100  
Arlington, TX 76014-2153