AUTHORIZATION FOR THE RELEASE OF SEMEN

To print this form, click on your browser's "PRINT" button OR download directly from our site.

ALL fields must be complete for form to be processed.

I am referring (patient's name) _____ to Midwest Sperm Bank to obtain semen specimens for therapeutic donor insemination. I have discussed, explained and reviewed all the risks and limitations of therapeutic donor insemination with my patient. I authorize my patient to obtain the specimens directly from Midwest Sperm Bank, or to telephone delivery orders to my office as needed. My patient has agreed that all specimens obtained from Midwest Sperm Bank are for personal use only. The therapeutic donor insemination will be performed under my direction and supervision.

Doctor's Signature: _____

License Number: _____

Date Signed (MM/DD/YYYY): _____/_____/_____

Print Name of Physician: _____

Hospital/Center Name: _____

Address: _____

City/State/Zip Code: _____

Telephone Number: _____ Fax Number: _____

Semen Specimens should be delivered to the following address if different from above:

Name: _____

Address: _____

City/State/Zip Code: _____

Please complete this form and either:

- **Fax:**
  630-810-0490
  Monday through Friday from 8:00 a.m. to 5:30 p.m. Central Time

- **Mail:**
  Midwest Sperm Bank
  4333 Main Street, Downers Grove, IL 60515