CASCADE CRYOBANK

Clinical Release Form

I, _____(Licensed Medical Practitioner, LMP), authorize the release of

sperm/semen samples from Cascade Cryobank for patient _____.

Select one option below:

- ☐ **This form authorizes Cascade Cryobank to release donor sperm/semen specimens directly to Recipient/Purchaser.**

- ☐ **This form authorizes Cascade Cryobank to release donor sperm/semen specimens directly to a clinic address by delivery or other shipping methods.**

The semen samples will be used for artificial insemination, and I certify that the patient has received a medical evaluation, is a suitable candidate for artificial insemination, and has agreed that specimens obtained from the cryobank are for their personal use only.

I/we understand that every pregnancy has at least a 3 to 4% risk of producing a child with a birth defect, developmental disability, or genetic disorder. Although genetic screening can decrease this probability to some extent, it is not possible to eliminate the risk entirely.

Purchaser/Patient Name:_____

Print LMP Name:_____

LMP Signature:_____

License Number:_____

Date:_____

Hospital/Center Name:_____

Address:_____

City/State/Zip Code:_____

Telephone Number:_____ **Fax Number:**_____

Please keep a copy for your records

This document must be mailed or emailed to:

19221 36th AVE W, STE. 201

Lynnwood, Washington 98036

CASCADE CRYOBANK

Email: **info@CascadeCryobank.com**

Please keep a copy for your records.

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For Cascade Cryobank Use Only:

DATE RECEIVED: _____

EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____