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:

4210 198th St SW, Ste 100

Lynnwood, Washington 98036

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: ____