MIDWEST
SPERM BANK

AUTHORIZATOIN FOR THE RELEASE OF SEMEN

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 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 preformed under my direction and supervision.

Doctor's Signature: _____

License Number: _____

Date Signed (MM/DD/YYYY) : _____

Print Name of Physician: _____

Hoispital/Center Name: _____

Address: _____

City/State/Zip Code: _____

Telephone 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, Mail, or Email the form to us. Contact information can be found below.

Midwest Sperm Bank
4334 Highland Ave Downers Grove, IL
1-630-810-0490 (Fax)
msbdg2@gmail.com