



MIDWEST
SPERM BANK

AUTHORIZATION 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

📍 4333 Main Street Downers Grove, IL

☎ 1-630-810-0490 (Fax)

🌐 msbdg2@gmail.com