



Department of Obstetrics & Gynecology
Fertility Consultants
Andrology/Embryology Laboratory

www.fertilityoregon.com
fertlab@ohsu.edu

Center for Health & Healing
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Portland, OR 97239-4501
Tel 503 418-3700
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Recipient Insemination Information and Physician's Authorization

Recipient:

Name Last, First, Date of Birth
Address Street, City, State, Zip
Home phone, Day phone
email @ Occupation
Circle one: Married, Single, Living with Partner, Living with Registered Partner

Partner:

Name Last, First
Day phone: () -
email @ Occupation

Selecting an OHSU Sperm Donor: (This information may be provided later, check on donor availability)

I / We have reviewed the OHSU Andrology Sperm Donor Profiles and authorize the use of donors listed below for therapeutic insemination.

1st Choice Donor # 2nd Choice Donor # 3rd Choice Donor #

Selecting an Non-OHSU Sperm Donor:

I / We authorize the use of Donor # from sperm bank for therapeutic insemination.

If my blood type is Rh negative, I recognize that I must inform my obstetrician that if I have been inseminated with an Rh positive donor so that I may receive appropriate care during pregnancy.

Recipient signature Date

Physician Authorization: I authorize OHSU University Fertility Consultants Andrology Laboratory to release donor semen specimens to (Recipient name) name for the purpose of achieving a pregnancy in an assisted reproductive procedure. I have informed the recipient of the risks and limitations of the procedure. The assisted reproductive procedure will be performed under my direction and supervision, or the procedure may be delegated to a physician or clinic which I authorize. The recipient has agreed that all specimens obtained from University Fertility Consultants Andrology Laboratory are for her personal use only.

Physician signature print name Date

Clinic/ Hospital/ Center

Address Street, City, State, Zip