CALIFORNIA CRYOBANK
REPRODUCTIVE TISSUE SERVICES

AUTHORIZATION FOR RELEASE OF SEMEN

A1

PATIENT INFORMATION

Patient Name _____
First Middle Last

Date of Birth _____ / _____ / _____
Month Day Year

AUTHORIZATION

I am referring the above patient to California Cryobank ("CCB") to obtain semen specimens for an assisted reproductive procedure. I have informed her of the risks and limitations of her procedure and authorize her to obtain the specimens from CCB. My patient has agreed that all specimens obtained from CCB are for her personal use only.

1) I understand that this authorization is valid for one (1) year unless I elect an extension below (see *Special Requests*)
2) I understand that my patient will be allowed to transport shipments to any address unless I initial below (see *Special Requests*)

Physician Signature _____ **Date** _____

SPECIAL REQUESTS

1) I wish to extend the validity of this authorization to two (2) years **Initial** _____
2) Ship specimens to my address ONLY (Do not allow patient pickups or direct-to-patient shipments) **Initial** _____

PHYSICIAN INFORMATION

Physician Name _____
First Middle Last Suffix

License Number _____ State Issued _____

Facility Name _____

Office Address _____

City _____ State _____ Zip _____ Country _____

Telephone _____ Fax _____

Email _____ Website _____

Contact Name _____

SHIPPING ADDRESS (IF DIFFERENT FROM OFFICE ADDRESS)

Facility Name _____ Contact Name _____

Address _____

City _____ State _____ Zip _____ Country _____

Telephone _____ Fax _____

Document must be faxed or mailed to: *Please keep a copy for your records*

Fax: (866) 625-7336 (**US and Canada**) (310) 826-1605 **(International)**

California Cryobank, Attn: New Accounts, 11915 La Grange Avenue, Los Angeles, CA 90025