

| NewYork-Presbyterian

Authorization for the Use of Anonymous Donor Sperm (ADS)

Patient Information: Patient Name:	Date of Birth:	
	ave considered the available options for achie	Cohen Center for Reproductive Medicine (CRM) of eving parenthood and have chosen to attempt
treatment. I/We understand that		a donor sperm bank and using the sperm for my/our ccur. I/We understand that there are some potential build be introduced into the patient.
State Department of Health and CRM's Andrology Laboratory pr	I registered with the Food and Drug Administ ior to the treatment cycle. CRM will only store	ration (FDA). The sample(s) must be delivered to re the sperm samples in preparation for a treatment gulations, state requirements, and professional
		he child(ren), and agree to care for, support and cts, as if it/they were my/our naturally conceived child.
for a minimum of ten (10) years use of sperm resulting in a live Additionally, Federal regulations with cycle-specific data regarding associated with this treatment who procedure will remain confident Health or other government again consultation.	after use of sperm not resulting in a live birth birth. As required by New York State, pregnas and reporting requirements obligate IVF prong the treatment cycle and the pregnancy out will be protected under the Privacy Act. Informial and will not be disclosed, except to author encies with my permission. I/We understand to ask questions, and any questions that	ograms to provide the Centers for Disease Control tcome. However, any and all personal identifiers mation obtained and identified with me/us during this rized employees of the New York State Department of
team.	J J J	
Patient Signature	Print Patient Name	Date
Witness Signature	Print Witness Name	Date
Partner Signature	Print Partner Name	Date
Witness Signature	Print Witness Name	Date
 Donor Bank	 Donor Number	Number of vials at CRM