Authorization for the Use of Anonymous Donor Sperm (ADS)

Patient Information:

Patient Name: _____ Date of Birth: _____

I/We have requested to be treated by The Ronald O. Perelman and Claudia Cohen Center for Reproductive Medicine (CRM) of Weill Cornell Medicine. I/We have considered the available options for achieving parenthood and have chosen to attempt pregnancy utilizing the sperm of an anonymous donor.

I/We understand that this procedure will involve purchasing the sperm from a donor sperm bank and using the sperm for my/our treatment. I/We understand that there is no guarantee that pregnancy will occur. I/We understand that there are some potential risks associated with this procedure, including the possibility that infection could be introduced into the patient.

The anonymous donor sperm sample(s) must be frozen by a sperm bank outside this institution that is licensed by the New York State Department of Health and registered with the Food and Drug Administration (FDA). The sample(s) must be delivered to CRM's Andrology Laboratory prior to the treatment cycle. CRM will only store the sperm samples in preparation for a treatment cycle. It is understood that all parties will abide by any applicable federal regulations, state requirements, and professional organization guidelines.

I/We accept this act as my/our own, and acknowledge my/our obligation to the child(ren), and agree to care for, support and otherwise treat any child(ren) born as a result of this procedure, in all respects, as if it/they were my/our naturally conceived child.

In accordance with New York State Department of Health requirements and FDA regulations, CRM will maintain medical records for a minimum of ten (10) years after use of sperm not resulting in a live birth, and for a minimum of twenty-five (25) years after use of sperm resulting in a live birth. As required by New York State, pregnancies will be reported to the sperm bank. Additionally, Federal regulations and reporting requirements obligate IVF programs to provide the Centers for Disease Control with cycle-specific data regarding the treatment cycle and the pregnancy outcome. However, any and all personal identifiers associated with this treatment will be protected under the Privacy Act. Information obtained and identified with me/us during this procedure will remain confidential and will not be disclosed, except to authorized employees of the New York State Department of Health or other government agencies with my permission. I/We understand that I/we may be contacted for a follow-up consultation.

I/We have been encouraged to ask questions, and any questions that I/we have asked have been answered to my/our satisfaction. I/We also understand that any future questions that I/we might have, may be answered by a member of the CRM team.

_____	_____	_____
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