Authorization for the Use of Frozen Sperm - Partner

I, ___________________________, authorize the use of my frozen sperm sample for the treatment of,
(Print Male Partner Name)

____________________________, my partner.
(Print Female Partner Name)

We understand that this authorization is valid for the current treatment cycle at The Ronald O. Perelman and Claudia Cohen Center for Reproductive Medicine (CRM) of Weill Cornell Medical College. If additional cycles are pursued, reauthorization will be required.

We understand that a notarized authorization to store and use frozen sperm is also required by the Andrology Laboratory.

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

______________________	______________________	__________	__________
Female Partner Signature	Print Female Partner Name	Date	Date of Birth
______________________	______________________	__________	
Witness Signature	Print Witness Name	Date	
______________________	______________________	__________	__________
Male Partner Signature	Print Male Partner Name	Date	Date of Birth
______________________	______________________	__________	
Witness Signature	Print Witness Name	Date	