Department of Obstetrics and Gynecology
University Fertility Consultants
Andrology/Embryology Laboratory
www.fertilityoregon.com

Center for Health and Healing
3303 SW Bond Ave., CH10F
Portland, OR 97239
TEL 503-418-3700 FAX 503-418-3708

RECIPIENT CONSENT FORM

I/We, _____ desire to be therapeutically inseminated for the purpose of conceiving a child to be treated in all respects as the natural child of myself/ourselves, freely and knowingly agreeing to the terms of this consent and understanding that I/we are bound to it.

I/We agree and consent that I/we will obtain the necessary sperm from a donor who shall not be advised of the identity of myself/ourselves, nor shall I/we ever be advised of the identity of the donor. It is also agreed that frozen donor sperm, quarantined for HIV (the AIDS virus) and Hepatitis C virus, will be used.

I/We hereby take cognizance of the fact that within the normal human population a certain percentage of children with physical or mental defects are born, and that University Andrology Laboratory/University Fertility Consultants cannot and will not be held responsible for the physical and mental characteristics of any child born as a result of therapeutic insemination. I/We therefore agree not to take any legal action whatsoever against University Andrology Laboratory/University Fertility Consultants personnel in the event of a physically or mentally deficient child. It is further understood and agreed that the nature of this agreement is such that it must remain confidential; therefore, I/we agree that the sole copy of this document will be maintained in the University Andrology Laboratory's confidential files.

_____ _____ / _____ / _____ _____
Recipient Signature Date Med. Rec. #

_____ _____ / _____ / _____ _____
Husband/Partner Signature Date Med. Rec. #

_____ ____ / ____ / _____
OHSU Clinical Staff Witness Signature Date

Patient Identity confirmed

_____ by ☐ Drivers License or other: _____
OHSU Clinical Staff Witness Print

To be notarized below **if not** witnessed by OHSU Clinical Staff as described above:

State of _____, County of _____

Signed or attested before me on _____ / _____ / _____ .

_____
Notary Public Signature

Notary Public for _____My commission expires ____ / ____ /_____