



▶ Please PRINT all information except where a signature is indicated ◀

DATE: _____

PATIENT NAME:

(Last) (First) (MI)

DOB: _____ SSN _____

Is currently under my care. She has had a normal Pap smear within the last year.

TYPE OF INSEMINATION:

- Husband/Partner Insemination
 - Name of Husband/Partner:

(Last) (First)

- Donor Insemination

I AUTHORIZE:

Oregon Health & Science University, Fertility Consultants, Center for Health & Healing, CH10F, 3303 SW Bond Avenue, 10th Floor, Portland, OR 97239-4501. Phone: (503) 418-3700; FAX: (503) 418-3708 FAX

to do up to 6-cycles of inseminations after which the patient will then be sent back to me for re-evaluation. I realize OHSU will only be performing the insemination and that the patient will be referred back to me with any questions regarding her fertility treatment.

▶ The patient will need to register with OHSU as soon as possible by telephoning (503) 494-8505 ◀

Must be signed by an M.D. or D.O.

(Physician's Signature)

(Printed Name)

Physician Information:

(Street Address)

(City, State, Zip Code)

(Phone) (FAX)

▶ RETURN THIS AUTHORIZATION TO OHSU FERTILITY CONSULTANTS ◀

School of Medicine

Department of Obstetrics & Gynecology

Division of Reproductive Endocrinology & Infertility

Fertility Consultants
Center for Health & Healing, CH10F
3303 SW Bond Avenue,
10th Floor
Portland, OR 97239-4501
tel 503 418-3700
fax 503 418-3708
www.fertilityoregon.com

Phillip E. Patton, M.D.
Professor & Director

Kenneth A. Burry, M.D.
Professor

Marsha Jan Gorrill, M.D.
Associate Professor

David M. Lee, M.D.
Assistant Professor