Consent for Artificial Insemination: Anonymous Donor

Name of Patient: _____

Name of Partner: _____

We, the Patient and Partner named above, are each over the age of twenty-one (21) years. By our signatures below, we request and authorize undersigned physician (Physician) and her/his designee(s) to inject Patient with prepared semen from an anonymous donor, which is a procedure called "Artificial Insemination". We authorize Physician to employ such assistance as may be necessary for the purpose of accomplishing the artificial insemination. We are eager to have a child and we believe that this artificial insemination will promote our mutual happiness and well-being.

We understand that several attempts at artificial insemination may be necessary and that Regional One Health does not warrant or guarantee that pregnancy or full term pregnancy will result from the artificial insemination.

To induce Regional One Health and Physician to render the services we have requested, we and each of us agree that:

- a) Under no circumstances will we require that the name of the donor of the semen be divulged to us or anyone else, and we, accordingly, forever waive all rights, if any, that we may have to know the name or identity of, or to obtain any information of any kind about, the donor.
- b) We, and each of us, acknowledge our obligation to care for, support, educate and otherwise treat and consider any child or children born as the result of such anonymous donor artificial insemination in all respects as though they were our natural child or children. Neither of us will never allege in any proceeding that the child or children born is/are other than legitimate, and we promise to recognize each such child or children as our lawful and legal heir(s).
- c) We recognize that no action or inaction on the part of Regional One Health, UT Regional One Physicians, Inc., their physicians or other employees or agents, in providing artificial insemination can either assure the health or well-being of the Patient or child (children) during or after pregnancy or childbirth or determine the physical or mental status of any child (children) born as a result of the procedure. We understand that pregnancy and childbirth both involve risks that are independent of whether conception occurs through artificial insemination or otherwise.
- d) Although reasonable safeguards will be employed, we acknowledge that there is a risk of Patient and/or child (children) being infected by diseases, including HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome).
- e) We accept the risks describes above, and release, discharge, indemnify, and forever hold harmless Regional One Health, UT Regional One Physicians, Inc., and their respective employees, agents, directors, officers, and contractors from any and all liability and responsibility of any nature whatsoever that may result from complications of pregnancy, childbirth, or delivery, from the birth of an infant or infants abnormal in any respect, from the heredity or hereditary tendencies of the child (children), or from any other adverse consequences that may arise following the artificial insemination authorized by the consent.

We acknowledge that we have been given an opportunity to ask questions about the proposed procedure and that all of our questions have been answered to our satisfaction. With full knowledge and understanding of the attendant risks and consequences of our decision, we each consent to the medical procedure described in this consent. We each acknowledge and affirm that we have given our consent and signed this consent from without or compulsion and of our own free will.

Patient Signature

Date

Partner Signature

Date

Patient's Printed Name



Consent for Artificial Insemination: Anonymous Donor Form No. ROH.541 (Created 5/15) *OB0481* 1 Copy - Medical Record 1 Copy - Patient 1 Copy - Partner



Partner Printed Name

Affix Patient Label

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Patient's Initials _____ Partner's Initials _____

Physician Attestation

The above mentioned patient and partner (if applicable) have been informed and counseled by me and others regarding the risks and benefits of the relevant treatment option, including non-treatment. The patient and partner (if applicable) expressed understanding of the information presented during the discussion.

Physician Signature

Date

Physician Printed Name

[Notary Page to Follow]





Affix Patient Label

Consent for Artificial Insemination: Anonymous Donor

[Notary Page for: Consent for Artificial Insemination: Anonymous Donor]

STATE of)) COUNTY of)	:SS			
()				
The foregoing instrument was	s acknowledged before me this	day of	, 20	_, by
	, referred to in this consent fo	orm as "Patient".		
My commission expires:				
	Notary Public			
STATE of)	:SS			
COUNTY of)				
The foregoing instrument was	s acknowledged before me this	day of	, 20	, by
	, referred to in this consent fo			

Notary Public



Affix Patient Label

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