Women's Health Care Associates
Normal and High Risk Obstetrics, Gynecology, and Infertility
7720 South Broadway, Suite 440
Littleton, Colorado 80122
303-795-0890

CONSENT TO ARTIFICIAL INSEMINATION – HUSBAND/MALE PARTNER

By signing this consent I/we are consenting to the artificial insemination procedure. The procedure for artificial insemination has been fully explained to me/us to my/our full and complete understanding and satisfaction. I/we understand the risks and benefits of the IUI procedure. I/we have signed the consent to the IUI treatment.

I/we understand there is a minimal risk of developing an infection from the IUI, not related to an existing infection which could result in uterine or tubal damage or an intra abdominal infection, although the likelihood is extremely rare.

I/we understand and take cognizance of the fact that during pregnancy, childbirth and delivery, the same type of complications can arise as with a child conceived by sexual intercourse. It is possible that the resulting child or children could be born abnormal, possesses undesirable traits for hereditary tendencies, or could have any other problems or disabilities of children conceived by sexual intercourse. In addition, I/we are aware that there is no sufficient evidence available which indicates that children born as the result of artificial insemination, (using separated and isolated sperm), have any increased risk of congenital anomalies, malformation, or other birth defects as compared with the general population.

I/we do hereby promise, undertake, and guarantee to hold harmless and to indemnify the physician(s) and all other persons connected with the intrauterine insemination procedure from all liabilities, claims, actions, damages, and losses of any nature whatsoever caused by or arising out of the artificial insemination. The procedure of artificial insemination has been fully explained to me/us to my/our full satisfaction and I/we are requesting the procedure to be performed on this date.

IUI# _____ Date _____

Please Initial:

_____ / _____I have had an opportunity to review the identifying information of the processed sample prior to insemination.

Patient Name (print) _____ Patient Signature: _____

Patient Name (print) _____ Patient Signature: _____

Clinic Representative Signature _____ Date: _____

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