Manhattan CryoBank

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AUTHORIZATION TO RELEASE FROZEN SEMEN

I am confirming (patient's name) _____

with date of birth (mm/dd/yyyy) _____is my patient.

I authorize her to obtain the specimens directly from Manhattan CryoBank and I understand that it is a policy of Manhattan CryoBank to renew this authorization annually.

I have informed her of the risks and limitations of her assisted reproduction procedure and that genetic and infectious disease screening can reduce this risk to some extent, but it cannot eliminate the risks entirely.

Sperm source (please check only one):

- ☐ Husband/Partner (name/DOB)_____
- ☐ Donor sperm
- ☐ Directed Donor (name/DOB) _____

Please provide vials for the following purpose:

- ☐ Intracervical Insemination (ICI/standard) vials.
- ☐ Intrauterine Insemination (IUI/pre-washed) vials.
- ☐ Assisted Reproductive Technologies (A.R.T.) vials.

My patient has agreed that all specimens obtained from Manhattan CryoBank are for her personal use only.

Specimen may be shipped to (please check all that apply):

- ☐ My office
- ☐ My patient is authorized to pickup the specimen
- ☐ My patient's home address
- ☐ This address:

_____

_____

Physician's Full Name:		
Specialty:	License #:	State Issued:
Physician's Signature:		Date:
Clinic Name/Address:		
Phone:	Fax:	