Manhattan CryoBank

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ANDROLOGY LABORATORY ♦ REPRODUCTIVE TISSUE BANK SERVICES ♦ SPERM CRYOBANKING ♦ EMBRYO/EGG STORAGE ♦ DONOR SPERM

AUTHORIZATION TO RELEASE FROZEN SPECIMEN

I am referring (patient's name) _____ to Manhattan Cryobank Inc. (Manhattan CryoBank), to obtain his/her frozen specimens for an assisted reproductive procedure.

I authorize him/her to obtain the following cryo-preserved reproductive tissue directly from Manhattan CryoBank:

- ☐ Embryos
- ☐ Oocytes
- ☐ Ovarian Tissue
- ☐ Sperm
- ☐ Testicular Tissue

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

Physician /Nurse Practitioner Signature:	Date:
Physician/Nurse Practitioner Name:	
Physician/Nurse Practitioner complete address:	
Phone:	Fax: