

Patient Name: _____
SSN: _____
Date: _____
Address: _____

Delaware Valley Institute of Fertility & Genetics
6000 Sagemore Drive, Suite 6102
Marlton, NJ 08053
Phone:856-988-0072

Dear Dr. _____

I _____ and my husband/partner
_____ request that the Delaware Valley Institute of
Fertility & Genetics terminate our participation in the **Cryopreservation
Program**. We also request to handle the cryopreserved sperm that is
stored at the Delaware Valley Institute of Fertility & Genetics in the
following manner: ***please, this form must be notarized.***

The sperm will be donated to the research project(s) carried out at the
Delaware Valley Institute of Fertility & Genetics. Research will not
involve transfer to other patients or animals, only the evaluation of
proteins and DNA to improve future IVF outcomes.

Sincerely Yours,

_____ Patient Printed Name	_____ Signature
_____ Husband/Partner Printed Name	_____ Signature
_____ Notary Public	_____ Date

Disposition sperm