

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 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 straw(s)/vials will be removed from the liquid nitrogen storage tank
and allowed to thaw in room temperature. Then they will be handled
according to OSHA procedures and regulations concerning handling and
disposing biological material.

Sincerely Yours,

Patient Printed Name

Signature

Husband/Partner Printed Name

Signature

Notary Public

Date

Disposition sperm