Release Authorization *(Version 2)*

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This form must be filled out and signed if the semen is to be delivered to a non-medical clinic or picked up personally at Cryos International – New York LLC.

The undersigned hereby authorizes Cryos International to deliver donor semen directly to:

_____ for her exclusive use.

(Print Recipient Name)

Physician's signature*: _____

Date: _____

Print Physician name: _____

Address of Physician office: _____

_____

Physician office telephone number: _____

*If a non-physician is authorizing delivery this person must be authorized to perform therapeutic donor insemination and documentation for this must be attached to this form.