

# 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.

