Delaware Valley Institute of Fertility & Genetics
6000 Sagemore Drive, Suite 6102, Marlton, NJ 08053
Telephone # (856) 988-0072 Fax # (856) 988-0056

CONSENT FOR THE RELEASE OF CRYOPRESERVED EMBRYOS

I/We hereby request and authorize Delaware Valley Institute of Fertility & Genetics (DVIF&G) to release my/our cryopreserved embryos identified below, directly to me/us or to _____(specify persons or entity). Delaware Valley Institute of Fertility & Genetics previously stored this specimen at my/our request. I/We now wish to have this embryos transferred to another medical facility. I/We understand that to continue to preserve the original biological properties of the embryos, it must remain cryopreserved in liquid nitrogen until such time as it is to be thawed according to the method specified by Delaware Valley Institute of Fertility & Genetics

I/We have been provided adequate opportunity to ask any questions I/we may have regarding the process of removing my/our embryos from storage and all of my/our questions have been answered to my/our satisfaction.

I/We understand that we have full and sole responsibility for the transport and disposition of our embryos once it is released by Delaware Valley Institute of Fertility & Genetics to me/us or to the person or entity designated by me/us above. I/We agree to assume full responsibility for all costs incurred relating to the transport, subsequent processing, storage and use of my/our semen. This cost may or may not be covered by my/our insurance. I/We hereby indemnify, release and hold harmless Delaware Valley Institute of Fertility & Genetics and its physicians, employees, trustees, officers and agents from any and all liabilities, claims, losses, damages or causes of action arising out of or relating to any events occurring with respect to the transport, storage, thawing or any use of my/our embryos to try to establish a pregnancy.

Vials/Straws to be Released: _____

Vials/Straws Remaining at Delaware Valley Institute of Fertility & Genetics: _____

Type of Specimen:
___ Oocytes
___ Zygotes
___ Embryos
___ Blastocysts

_____	_____	_____
Name of Patient	Signature of Patient	Date
_____	_____	_____
Name of Partner	Signature of Partner	Date
_____	_____	_____
Name of Lab Representative	Signature of Lab Representative	Date

PATIENT/PARTNER ID INFORMATION_____