Rochester Regional Cryobank
University of Rochester Medical Center
Med Box 668; Room 2-4329
601 Elmwood Avenue
Rochester, NY 14642

DATE:

TO: Andrology Laboratory/Rochester Regional Cryobank
University of Rochester Medical Center

FROM:

I hereby request that all vials of semen stored at the Rochester Regional Cryobank be destroyed as of the above date.

(Please print) Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Telephone Number: _____

Social Security Number: _____ Acct number: _____

Do you also have sample stored with IVF? Yes or No
If yes, would you like those sample destroyed also? Yes or No

*Please include a copy of you're drivers license, Thank you*

Signature: _____