Physician/Health-Care Provider's Permission

Practitioner/Clinic Name: _____

Contact Information: _____

Patient Information:

Patient Name: _____ Date of Birth: _____

Permission Granted to:

Provider Name: _____Specialty/Type of Treatment: _____

Reason for Permission:

There is no reason to believe that massage or bodywork treatments will harm this patient's progress. However, please note the following considerations:

Description of condition:

_____

_____

_____

_____

Possible interactions with medications:

_____

_____

Special instructions:

_____

_____

_____

Permission Granted by:

Physician/Health-Care Provider Name: _____
Phone: _____ Email: _____

Signature: _____ Date: _____

Please note: Should you notice anything unusual or significant during treatment, please notify this office immediately. Otherwise, any update at the conclusion of care would be appreciated.