Physician/Healthcare Provider's Permission

Patient 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

Physician/Healthcare Provider Name:

Phone:	Fax:	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.