Practitioner/Clinic Name:	Physician/Health-Care
Contact Information:	Provider's Permission
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 bodyworthe following considerations:	rk treatments will harm this patient's progress. However, please note
Description of condition:	
Possible interactions with medications:	
Special instructions:	
Permission Granted by	
Physician/Health-Care 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.

