



## Physician Permission Form

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:

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Possible interactions with medications:

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Special instructions:

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### 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.*