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, CranioSacral therapy, Visceral Manipulation 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:_____ 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.