

## **Physician Release for Treatment**

Patient Name:	Date of Birth:
The above patient is under my care for	
☐ Pregnancy	
☐ Oncology Care	
☐ Other (please specify):	
I feel this patient is suitable to undergo massage therapthe next 30 days.	py by a licensed massage therapist within
Any specific restrictions or comments:	
Physician Signature / Printed Name	Date