PHYSICIAN/ HEALTH CARE PROVIDER'S PERMISSION FOR MASSAGE OR BODYWORK

PLEASE PRINT CLEARLY

Practitioner/ Clinic Name: _____

Contact Information: _____

_____

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

PERMISSION GRANTED TO *Sara Bliss, LMT, BLISS Massage Therapy – Matthews Executive Center, 325 Matthews Mint Hill Road Suite 107, Matthews NC 28105*

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 BY Physician/ Health Care Provider Name

_____

Phone_____ 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.