Physician/Health Care Provider's Permission

If you have a medical condition that requires permission from your doctor to receive massage, please ask your doctor to fill this out *before* your massage, and bring it to your appointment.

Practitioner/Clinic Name _ **Mary Teter, LMT** _____Phone **303-408-1751**
Address _____

Patient Information

Patient Name _____ Date of Birth _____

Permission Granted to

Provider Name **Mary Teter, LMT** Specialty/Type of Treatment **Massage Therapy**

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

_____

_____

Possible interactions with medications

_____

_____

Special instructions

_____

_____

Permission Granted by

Physician/Health Care Provider Name _____
Phone _____ E-mail (optional) _____

Physician/Health Care Provider's Signature _____ Date _____

Please note: Should you notice anything unusual or significant during treatment, notify the provider listed above immediately. Otherwise, any update at the conclusion of care would be appreciated.