

Physician Permission Form

Physician Name: _____

Physician Address: _____

Physician Telephone: _____

Physician Email: _____

I doctor _____ hereby give consent for my patient _____ to receive massage therapy from Becky Hirschey, LMT.

There is no reason to believe that massage or bodywork treatments will harm this patient's progress. However, please note that the following considerations/medication warrant special concern:

If you notice anything unusual or suspicious in the treatment or progress of this patient, please notify me immediately.

Physician Signature _____ Date _____