



Comfort Touch Medical Massage Release Form

Fax Number: 610-584-8098

Date: _____

Your patient _____, DOB _____ currently in your care is considering therapeutic massage at The Body Serene. A concern was raised during a review of your patient's medical history that needed further clarification. In order to provide the most beneficial massage session, we request your input regarding any necessary restrictions, exclusions or contraindications for massage therapy. If you have any questions, please do not hesitate to call.

Regarding your request for information on any restrictions, exclusions or contraindications for therapeutic massage for _____ (patient); I have reviewed this patient's record and recommend the following:

Physician Signature: _____

Date: _____

CONFIDENTIAL: This fax message and any attachments hereto are confidential and are intended solely for the information and use of the intended recipient(s). If you are NOT an intended recipient or authorized personnel, YOU ARE HEREBY NOTIFIED that any use, dissemination, distribution or copying of this communication is STRICTLY PROHIBITED. If you have received this communication in error, please notify us immediately by return fax or telephone and delete and destroy all copies of the original message from your files.

OFFICE USE ONLY:

Client Phone Number: _____

Date: _____