waterfordplace
Cancer Resource Center

Medical Release Form

Participant Name: _____ Birthdate: _____

I,_____authorize my physician to release my personal health information to Waterford Place Cancer Resource Center for the purpose of participation in the movement and yoga programs, massage therapy, oncology facials, craniofacial therapy and/or acupuncture.

Participant Signature: _____ Date: _____

To Be Completed by Physician

Cancer Type: _____

___/____/_____ Date of diagnosis

___/____/_____ Date of treatment completion

___ Patient has completed treatment.

___ Patient is receiving supportive or palliative care only.

___ Patient is in or will be in active treatment

My patient has permisison to participate in the following Waterford Place Cancer Resource Center programs: (Please check all that apply)

____ Movement Programs (Including Group Exercise and Yoga)

____ Complementary Therapies (Including Massage, Facials, Vibrational Sound and Reflexology)

____ Acupuncture

Please list any specific restrictions:

_____

_____

_____

Physician Name (print): _____

Physician Signature: _____ Date: _____

Medical Office Name / Affiliation: _____

Medical Office Phone Number: _____

PLEASE FAX COPY TO WATERFORD PLACE CANCER RESOURCE CENTER AT 630.800.1768