waterfordplace
Cancer Resource Center

Autorización para Solicitar Expedientes Médicos

Para ser Llenada por el Participante:

Fecha: _____ Nombre del Participante:_____ Fecha de Nacimiento: _____

Yo, _____ autorizo a mi médico que dé mi información personal de salud a Waterford Place Cancer Resource Center para el propósito de la participación en los programas de movimiento y yoga, terapia de masage, faciales oncológicos, terapia craneofacial y/o acupuntura.

Firma del Paciente: _____ Fecha: _____

To Be Completed by Physician:

Movement and Yoga Programs consists of:

- 50 minute, Instructor led muscular strength / endurance, balance and flexibility training

I approve of the aforementioned patient participating in Waterford Place Cancer Resource Center programs. Please list any specific restrictions:

_____

_____

Complementary Therapies (Oncology Massage, Oncology Facials, Reflexology) consists of:

- Light, 40-45 minute sessions for stress reduction

I approve of the aforementioned patient participating in Waterford Place Cancer Resource Center programs. 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