waterfordplace Cancer Resource Center

Autorización para Solicitar Expedientes Médicos

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

___/____/_____ 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