

**Essential Medical Massage  
Plano, Texas**

**Healthcare Provider Release Request Form**

Name of Doctor \_\_\_\_\_ Date \_\_\_\_\_

Re: Release for Oncology Massage Therapy

Dear Dr. \_\_\_\_\_,

Your patient, \_\_\_\_\_, has requested massage therapy to be provided by myself, a certified medical massage practitioner with oncology training, at my office that is located at 2301 Ohio Dr., Suite 214, Plano, Texas.

It is my policy to provide oncology massage therapy only if the patient's healthcare provider has reviewed this request. In addition, if the patient has any high risk considerations, has experienced any healthcare complications or has any contraindicated conditions, I request a written release from the patient's healthcare provider stating such limitations and any precautions that you feel to be appropriate. I would appreciate it if you would verify your clearance for this treatment by your signature below and returning this form to me (via fax) at your earliest convenience. This verification can be modified or withdrawn at any time should your patient's health status change.

Thank you for your time and assistance.

Sincerely,

Phoebe Courcy, LMT, MMP, CPMT

Essential Medical Massage

www.EssentialMedMassage.com

[pcmedmassage@yahoo.com](mailto:pcmedmassage@yahoo.com) 214-864-9463

Signature of Patient:

\_\_\_\_\_

Healthcare Provider Information:

Patient's healthcare status is (please circle one) normal progression special considerations (detail below)

Specific limitations or precautions:

Name (please print): \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_