Essential Medical Massage

Plano, Texas

Healthcare Provider Release Request Form

Name of Doctor _____ Date _____

Re: Release for Pediatric Massage Therapy

Dear Dr. _____,

Your patient's parent/caregiver, _____, has given me permission to contact you. She has requested pediatric massage therapy for your patient, _____. This therapy will be provided by myself, a certified pediatric massage practitioner (CPMT), at my office that is located at 2301 Ohio Dr., Suite 214, Plano, Texas. I also have advanced training in pediatric oncology massage therapy.

It is my policy to provide pediatric massage therapy only if the child's healthcare provider has reviewed this request. In addition, if the child has any high risk considerations, has experienced any healthcare complications or has any contraindicated conditions, I request a written release from the child'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 This verification can be modified or withdrawn at any time should your patient's health status change.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, CPMT

Essential Medical Massage

www.EssentialMedMassage.com

pcmedmassage@yahoo.com 214-864-9463

Signature of Parent:

_____

Healthcare Provider Information:

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

Specific limitations or precautions:

Name (please print): _____ Phone: _____

Signature: _____