Umbrella Therapeutic Fitness

Physician's Release Form

Dear Doctor:

Your patient _____ wishes to take participate in adapted and therapeutic fitness programming offered through Umbrella Therapeutic Fitness. This program may include use of fitness equipment such as free weights, weight machines, and cardio machines; gymnastics equipment including trampoline, beam, parallel and horizontal bars; and chlorinated swimming pools. The program may increase in duration and intensity over time. We want to ensure medical clearance by seeking your advice in setting limitations to their activities if warranted. By completing this form, you are in no way assuming responsibility for our therapeutic fitness programming. Please identify any recommendations or restrictions for your patient below.

Patient Consent and Authorization

I consent and authorize Dr. _____ to release to Umbrella Therapeutic Fitness, the health information listed below for _____. I understand that this consent is revocable except to the extent action has already been taken. Authorization is not valid after one year from date of signature. Further disclosure or release of _____'s health information is prohibited without specific written consent.

Physician's Recommendation

The patient is medically cleared for a therapeutic fitness program. YES NO

I am aware of atlantoaxial instability in this patient. YES NO

If patient has atlantoaxial instability, they have had a full radiological examination within the past year. Date of Last Examination _____

The patient should not engage in the following activities:

_____

_____

_____

_____

Physician's Signature _____ Date _____

Physician's Name (Print) _____ Phone _____