Physician Release Form

Your patient, ___________________________________ wishes to start a personalized **exercise** program that will include Pilates as well as Fascial Stretch Therapy. As a participant in this program, your patient will be instructed in proper **exercise** techniques working one on one with a personal trainer or in a small group setting of no more than 6 participants.

Are there any medical factors in your patient's history or any medications that are currently being taken which would affect **exercise** programming or your patient's ability to participate in a non-medically supervised **exercise** program?
Please Circle: Yes No
If yes, please list and explain:

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Please identify any recommendations or restrictions that are appropriate for your patient in this **exercise** program:

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My patient, _____________________________________, has my approval to begin an **exercise** program with the recommendations or restrictions stated above.

Physician Name:_____________________________**Phone**:_____________________

Physician Signature:______________________________**Date**:________________

Participant Signature:_____________________________**Date**:________________