CHERICA VOYLES, LMT

Yoga | Ayurveda | Fitness

MEDICAL RELEASE & CLEARANCE FOR MASSAGE THERAPY,
POWER YOGA OR MOVEMENT & MOBILITY FITNESS

Last Name	First Name	Middle Initial	DOB

I, _____ grant permission for _____
(Client Name) (Healthcare Provider/Primary Care Physician/Specialist)

to provide or exchange information with Cherica Voyles, LMT regarding the following conditions:

_____

_____

_____

for the time frame beginning _____ and ending _____ .

This permission may be revoked at any time either verbally or in writing.

_____
(Healthcare Provider/Primary Care Physician/Specialist)
further confirms that the client does not suffer from any medical, physical, mental, emotional, or social conditions where (please circle) *massage therapy, power yoga, or movement & mobility fitness* may be contraindicated and is cleared as indicated below.

____ Cleared without restrictions

____ Cleared for relaxation massage

____ Cleared for deep tissue/therapeutic massage, power yoga, or movement & mobility fitness

Client Signature	Date
Physician Signature	Date