PHYSICIAN/HEALTH-CARE PROVIDER'S PERMISSION

Practitioner/Clinic Name: Connie Yust, CMT, CST, NCMT / HealthyFocus, LLC

Contact Information: Bsns Cell: 620-966-0149 (www.healthy-focus.net)

Patient Information:

Patient Name: ___________________________________ Date of Birth: _______________

Permission Granted to:

Provider Name: ***Connie Yust w/ HealthyFocus, LLC***

Specialty/Type of Treatment: ***Massage Therapy:*** ____

Reason for Permission:

There is no reason to believe that massage or bodywork treatments will harm this patient's progress. However, please note the following considerations:

Description of condition:

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Possible interactions with medications:

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Special instructions:

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Permission Granted by:

Physician/Health-Care Provider Name:____

Phone: _________________________ **Fax:** _________________________ **Email:** _____________________________

Signature: _____________________________________ **Date:** ___________________

Please note: Should you notice anything unusual or significant during treatment, please notify this office immediately. Otherwise, any update at the conclusion of care would be appreciated.