waterfordplace
RUSH Cancer Resource Center

Medical Release Form

Participant Name: _____ Date of Birth: _____

I authorize my provider to release my personal health information to Waterford Place Cancer Resource Center for the purpose of participation in the movement and yoga programs, massage, facials, vibrational sound therapy, reflexology, and acupuncture

Participant Signature: _____ Date: _____ Time: _____

To Be Completed by Provider

Type of Cancer: _____

Date of Diagnosis: _____

Date of Treatment Completion: _____

☐ Patient has completed treatment

☐ Patient is receiving supportive / palliative care

☐ Patient is in or will be in active treatment

My patient has permission in the following Waterford Place Cancer Resource Center programs.
(Please check all that apply)

☐ Movement Programs (including group exercise and yoga)

☐ Integrative Medicine Therapies (including Massage, facials, vibrational sound therapy, reflexology, and acupuncture)

Restrictions and contraindications, *if any*:

_____

_____

Provider Name (please print): _____

Provider Signature: _____ Date: _____ Time: _____

Medical Practice Name / Affiliation: _____

Medical Practice Phone Number: _____

INTERPRETER ATTESTATION: Interpretation has been provided by _____ □ Phone