

# Fitness + Wellness

## Physician's Authorization

On the Health History form you just filled out, you identified risk factors or concerns about your current state of health that may impair your ability to exercise safely. For this reason, please have your physician complete and return this form to me.\* I apologize for the inconvenience, but I want you to be safe.

Risks/Concerns: \_\_\_\_\_

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I hereby give my physician, \_\_\_\_\_, permission to disclose any pertinent medical information that would assist in me exercising safely.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name \_\_\_\_\_

Physician's Phone \_\_\_\_\_

### *For Physician Only:*

Please check one of the following statements:

\_\_\_\_\_ I concur with my patient's participation with no restrictions.

\_\_\_\_\_ I concur with my patient's participation in an exercise program if he/she restricts activities to:

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\_\_\_\_\_ I do not concur with my patient's participation in an exercise program due to the following reason/s:

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Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*(Return to: Cindy Pavell/P.O. Box 8186/Springfield, VA. 22151)**