www.Lifestylechanges2health.com

Physician's Consent Form

Dear Dr. _____

Your patient, _____ is interested in Health Coaching provided through Lifestyle Changes 2 Healthand has authorized you to release the information below. To help assure the safety of the program, we are requesting you ***complete this form and return it to me as indicated below*** so we can follow your recommendations. Thank You.

_____, **Health-Wellness Coach at Lifestyle Changes 2 Health**

Please scan and return to: **Coach Linda Crawford, Lifestyle Changes 2 Health via email: coachlinda@lifestylechanges2health.com**

I _____, give my consent to Dr. _____
to release only appropriate medical information as necessary to **www.Lifestylechanges2health.com**

PATIENT SIGNATURE: **_____** ***DATE:*** **_____**

PHYSICIAN'S NAME (Please Print): _____

ADDRESS: _____ CITY: _____ STATE: _____

PHONE NUMBER: _____ EMAIL: _____

NO RESTRICTIONS
{ } I have consulted with this individual concerning acceptable levels of exercise and I have informed him/her of the potential adverse health consequences, including death, that may result if he/she exceeds the prescribed levels of exercise I have recommended.

RESTRICTIONS
My patient is restricted of participation in the health coaching activities/program I have indicated below. I have indicated specific guidelines and/or restrictions for my patient.

MY PATIENT IS NOT PERMITTED TO PARTICIPATE IN:
{ } Aerobic Activities (e.g.: walking, rowing, stair climbing, aerobics, elliptical cross trainer)
{ } Strength Activities (e.g.: machine, free weight, band, body resistance)
{ } Flexibility (e.g.: stretching exercise, yoga)

DISEASE OR CONDITION SPECIFIC EXERCISE AND/OR DIETARY GUIDELINES:

{ } _____

PHYSICIAN SIGNATURE: **_____** ***DATE:*** **_____**