



Physician Prenatal Release

Client

Name (last, first, MI):

Your patient (named above) is seeking prenatal therapeutic massage services provided by Tyann Sarkisian, a certified prenatal and perinatal massage therapy practitioner.

Prior to administering prenatal massage, it is my policy to require the prenatal client to consult their physician regarding their health and suitability to receive massage therapy.

By your signature below, please certify that you clear your patient (named above) for prenatal massage therapy services. If there are specific concerns, clarifications and/or limitations that I should observe while administering prenatal massage therapy to your patient, please note these below.

This certification may be modified or revoked by you at any time, in writing or by contacting me directly, should your patient's health status change.

I look forward to working with your patient.

Tyann Sarkisian, CMT
404.630.4097

Physician notes

Categorize the patient's pregnancy (circle one): Low risk High risk

Concerns, clarifications, limitations, etc:

Physician information

Print name:

Signature:

Phone:

Date:

Client agreement

By my signature below, I agree to the following statement(s):

1. I accept my physician's evaluation of my pregnancy regarding my suitability for prenatal massage therapy services.
2. Information contained on this form will never be released to or viewed by any third party for any reason without my prior written consent.

Client signature

Signature:

Date: