

physician release



Dr. _____,

Your patient _____ would like to begin a Yoga / Yoga Therapy program under the direct instructions and supervision of licensed physical therapist, Melissa Weston Valentine MPT, MPH, RYT. After reviewing responses to our screening questionnaire, your medical opinion and recommendations concerning his/her participation in Yoga would be greatly appreciated. If you are unfamiliar with the Yoga or Yoga Therapy method for exercise and would like more information, please do not hesitate to contact us at 206-419-7285 or via email at Melissa@discoveryogatherapy.com.

Please provide the following information and return this form to

Melissa Valentine
512 15th Ave; Kirkland, WA 98033.

Are there any specific concerns or conditions that I should be aware of before this individual begins participating in Yoga? _____ Yes . _____ No

If yes, please specify:

This individual may participate in Yoga _____ Yes _____ No, because _____

***physician's
signature:*** _____

physician's printed name

address: _____

phone: _____ ***fax:*** _____

Thank you with your help getting your patient started on a Yoga &/or Yoga Therapy program.