Lightway Healing Therapeutic Massage, LLC
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Stacy Viney-Broussard, LMT 6001

Physician's Permission

Physician's Name: _____

Physician's Address: _____

Physician's Telephone: (_____) _____

Patient's Name: _____ Age: _____

Patient's Date of Birth: _____ Patient's Telephone: _____

Patient's Address: _____

I have been treating this patient since _____ for the following condition(s): _____
_____
_____
_____
_____
_____

There is no reason to believe that massage or bodywork treatments will harm this patient's progress. However, please note that the following **considerations/medications** warrant special concern:

_____
_____
_____
_____
_____

Should you notice anything unusual or suspicious in the treatment or progress of this patient, please notify my office immediately.

Physician's Signature: _____ Date: _____

Printed Physician's Name: _____