



**PHYSICIAN'S STATEMENT AND CLEARANCE FORM**

Information Requested for:

Physician's Name:

Phone#

PLEASE CHECK THE STATEMENT WHICH REFLECTS YOUR WISHES:

- \_\_\_\_ 1. I concur with my patient's participation with no restrictions.
  
- \_\_\_\_ 2. I concur with my patient's participation if he/she restricts activities to \_\_\_\_\_
  
- \_\_\_\_ 3. I do not concur with my patient's participation in this program.

REASON:

- \_\_\_\_ 4. Other:

Comments:

\_\_\_\_\_  
(Physician Signature)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date)

I hereby give my physician permission to release any pertinent medical information from my medical records to the staff at American Family Fitness Center.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date)