Healthcare Provider Release for Pregnancy Massage Therapy

Your patient, ____, has requested pregnancy massage throughout her pregnancy. These services are not meant to replace appropriate medical prenatal care but to act as an adjunctive form of care. When an individual's pregnancy is high risk, or if she has experienced any condition contraindicating massage, it is my policy to work with her only if her Maternity Healthcare Provider has reviewed this request. Please verify your clearance of this request for Pregnancy Massage by signing below. Please also list any precaution or limitations which you feel to be appropriate.

Precautions or limitations:____

Signature of Healthcare Provider: ______________________________________ Date: ___________________________

Name of Healthcare Provider: ____

Thank you for your assistance,

Julie Barton, LATC, LMBT#6489, CSCS
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