DEDICATION HEALTH
Innovative Concierge Medicine

MEDICAL RELEASE FORM

Date _____

Dear Doctor:

Your patient,_____wishes to start a personalized training program. The activity will involve the following:

If your patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate the manner of the effect (raises or lowers exercise capacity or heart-rate response):

Type of medication(s) _____

Effects _____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

_____

_____

_____

Thank you.

Sincerely,

_____ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Signed: _____

Date:_____ Phone: _____

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