



---

**Physician's (or Health Care Provider's) Medical Release for  
Mind/Body/Fitness Classes**

We are requesting approval for your patient \_\_\_\_\_  
*Patient Name*

to participate in exercise, massage, yoga and other fitness programs at LivingWell  
Cancer Resource Center.

\_\_\_ May Participate

\_\_\_ May NOT Participate

Please list any limitations or contraindications:

---

---

---

---

\_\_\_\_\_  
**Physician or Health Care Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**(Please print physician name)**

**Please fax to:** LivingWell Cancer Resource Center, 630-262-1110

**Or**

**Send/Drop off to:** LivingWell Cancer Resource Center, 1803 W. State St., Geneva, IL 60134