Medical Release Form

Please have your Medical Physician fill out this form and return to representative or email to admin@cmooreselfcare.org
All information collected is strictly confidential and will become part of your medical record.

PATIENT INFORMATION

Your patient _____, has requested participation in the program from CMoore Self-Care.

CMoore Self-Care provides comfort and relief for those with cancer, through integrative therapies, alleviating side effects and improving quality of life.

We partner with Licensed Massage Therapists who are Oncology trained. We use safe chemical free products to combat skin side effects such as radiation dermatitis, rashes, itchiness, redness, severe dryness, etc., that develop from chemotherapy, radiation, surgery or non-cancerous medications.

Skin care or massage professional treatments along with education are offered at each visit. The client will receive products for a home care routine to continue the benefits of the professional treatment. Services are customized to patient conditions and concerns at the time of the visit.

We are in no way to replace medical advice and we are totally transparent. If you require more information, copies of training certifications, copies of licenses or product ingredient sheets we will be happy to provide them.

MEDICAL PROVIDER RELEASE

I, _____, represent that _____

has the following condition: _____

I authorize and release _____ to receive skin care and/or massage treatments as part of the wellness program from **CMoore Self-Care**.

LIST ANY ALLERGIES:		
LIST ANY PRECAUTIONS:		
ADDITIONAL COMMENTS:		
PHYSICIAN NAME (PRINT):		
PHYSICIAN SIGNATURE:		DATE:
PHYSICIAN LICENSE NUMBER:		
PHYSICIAN PHONE NUMBER:		
PHYSICIAN EMAIL:		