

# Medical Release Form

Dear Doctor,

Your patient, \_\_\_\_\_, wishes to start a personalized exercise program. This program will include cardiovascular, resistance and flexibility training.

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect).

Medications \_\_\_\_\_

Effect \_\_\_\_\_

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

---

---

---

---

Sincerely,

Beth Novick

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

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone