# PHYSICIAN RELEASE FORM

Maple Tree CANCER ALLIANCE

**Patient Name** _____ **Date of Birth** (MM/DD/YR) _____

**Phone** _____ **CPT Code(s)** _____

**E-mail** _____

**Physician Name** _____ **Physician Phone** _____

**Physician Address** _____

**City** _____ **State** _____ **Zip Code** _____

**Exercise Restrictions** _____

_____

_____

**Medications that may affect exercise response** _____

_____

_____

_____

_____

I hereby give medical approval to the person named above to participate in a post-rehabilitation program that may include cardiovascular, resistance training, and functional conditioning for the body.

**Physician's Signature** _____ **Date** _____

***Please submit this release form through direct messaging to:***
*WellDirect Address: mapletree@direct.mywelld.com (note: WellDirect is a Direct-verified HISP)*
*You may also submit referrals through our fax line: (937) 688-3940*