

PHYSICIAN'S STATEMENT & RELEASE FORM

Patient: _____

Physician: _____

Address: _____

Phone: _____

Please check one of the following and thereby indicate your approval or disapproval:

- I APPROVE of my patient's participation without any restrictions.
- I APPROVE of my patient's participation in this program, but with the following restrictions and/or guidelines: _____

I DO NOT approve of my patient's participation in this program and understand that my patient will not be accepted into the program.

COMMENTS: _____

Signature of Physician _____