440 GROVE STREET, WORCESTER, MA 01605
(508) 852-8209 | WORCESTERFITNESS.COM

PHYSICIANS RELEASE OF INFORMATION

Dear Doctor

Your patient has expressed an interest in participating in a health and wellness program at Worcester Fitness.

Worcester Fitness provides health, fitness and nutritional programs to all populations based on scientific principles. These principles and guidelines have been developed and recommended by the American College of Sports Medicine, and professionals like yourself. The programs are intended to serve as extensions of your patient care.

Our programs are designed to meet a person's individual needs based on an initial assessment of their current health and fitness status. Each member's evaluation includes an overall cardiovascular risk stratification, a resting heart rate and blood pressure screen, a sub-maximal aerobic bicycle ergometer test, a body composition measurement, and a flexibility and strength assessment.

Based on our preliminary screening, your patient's medical history indicates a need for approval prior to engaging in the assessment and subsequent program. Please complete this referral form on the opposite side by listing any contraindications, restrictions, and recommendations you may have. Below is your patient's signature for a relevant medical document release, if applicable.

We would be delighted to further inform you about our programs or show you our facility. Please feel free to call if you have any questions or concerns.

I, _____, agree to the release of medical records to Worcester Fitness for purposes of evaluation prior to exercise programming, and/or testing.

I understand that you, my physician, will release only the necessary records from my medical files to be used in the evaluation of my health condition so that I may participate in the Worcester Fitness program.

Physicians Name : _____ *Phone:* _____

Address : _____

Member Signature : _____ *Date:* _____