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I, _____, give my consent for AZ Bodyworks to receive any medical related information my physician deems necessary in order for me to safely and effectively receive massage and bodywork. I understand AZ Bodyworks will not share this information and practices strict client confidentiality.

Signature _____

Date: _____

Physician's Name: _____

Physician's Address:

Physician's Telephone: (____) _____

I have been treating this patient since _____ for the following condition(s):

I give consent and approve of any massage or bodywork given to my patient,
 _____.

Please note that the following considerations/medication warrant special concern:

Physician's

Signature _____ Date _____