

**Release of Medical Information to Serenity Yoga & Pilates Studio, LLC C/O  
Marcie Evans, Manager**

From the desk of: Marcie Evans, M.A., E-R.Y.T., A.C.S.M., ACE

Date:

Dear Physician or Therapist, we are writing you because your patient has checked a condition on our waiver that requires medical release prior to practice of yoga or Pilates in our studio. We would like \_\_\_\_\_, a future client at Serenity Yoga & Pilates Studio, LLC, to obtain a physician or physical therapist's signature for medical release prior to exercising at our studio.

In addition to this medical release form we need your permission to train your patient and your signature. I would also appreciate the following pertinent recommendations to be released, as they are needed for safe exercise prescription.

- Medical release to exercise with signature from physician
- Diagnosis/or special condition that may affect exercise or require modifications
- Approximate safe heart rate range
- Any modifications needed or contraindications to exercise
- Suggestions for exercise (e.g. no isometric contractions, no inverted exercises, no supine postures)
- Any other suggestions or recommendations for this client

Thanks for your time and recommendations. If you have any questions or concerns, please feel free to call me at (319) 541-4997 or email me [serenity.yp@gmail.com](mailto:serenity.yp@gmail.com).

Sincerely,

Serenity Yoga & Pilates Studio, LLC  
Marcie Evans, Manager, M.A., E-R.Y.T., A.C.S.M., A.C.E.  
Coralville, IA  
52241

**Release of Medical Information, Release Form and Physician's Signature**

Patient \_\_\_\_\_ (Telephone) \_\_\_\_\_ (Date of birth) \_\_\_\_\_

1. Information to be released from physician to exercise consultant

- Exercise test (date) \_\_\_\_\_
- Most recent history and physical exam
- Important laboratory results (specify) \_\_\_\_\_
- Medical release to exercise with signature from physician or OB/GYN
- Results from treadmill test (if it is a recommendation for diagnosis)
- Approximate safe heart rate range
- Modifications needed or contraindications to exercise
- Suggestions for exercise (e.g. no isometric contractions, no inverted exercises, no supine postures, no prone postures)
- Any other suggestions/recommendations for this client

2. **Information to be released to:**

Name of person/organization  
 Marcie Evans Manager/ Serenity Yoga & Pilates Studio, LLC  
 Telephone 319-541-4997  
 Email: serenity.yp@gmail.com

3. Purpose of disclosure information: Beginning exercise programs with a potential contraindication such as pregnancy, hypertension, or significant precursors to cardiovascular disease

4. I do not give permission for disclosure or re-disclosure of this information other than that specified above.

5. I request that this consent become invalid 90 days from the date I sign it or the following date \_\_\_\_\_

6. I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance of this consent.

7. If there are significant changes in patient's condition, patient will hold responsibility to contact Serenity Yoga & Pilates, LLC and physician immediately regarding potential changes in exercise programming.

Physician's Signature \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

