

**MAC**  
**Maintaining Active Citizens**  
*Your Area Agency on Aging*  
Dorchester, Somerset, Wicomico, Worcester

**Physician Release to Participate in an Exercise Program at the Richard Henson Health and Wellness Facility**

To: (Physician's Name)  
(Clinic Address)  
(City, State, Zip)  
(Phone) (Fax)

From: (Name & Title)  
(Address)  
(City, State, Zip)  
(Phone) (Fax)

Re: (Client's Name) (Client's DOB)

Dr. (Name)

Your patient, \_\_\_\_\_, is planning to begin a membership at the Richard Henson Health and Wellness facility at MAC Incorporated. All exercise programs are developed based on the individual's health history, current level of fitness and desired goals. Our fitness instructors hold accredited certifications, as well as CPR and First Aid certifications. We value your input regarding this client's exercise prescription. At this time we are requesting the release of information that you feel would be beneficial to us in developing a safe and effective exercise program. If you know of any medical reasons that would contraindicate or limit this individual's ability to participate, please indicate your concerns. If you have any question, please call us at 410-742-0505.

- I know of no reason why \_\_\_\_\_ may not participate in an exercise program and fitness testing.
- \_\_\_\_\_ may participate in an exercise program and fitness testing with the following precautions/limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- I recommend that \_\_\_\_\_ not participate in an exercise program at this time.

(Physicians Signature)

(Date)

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I hereby consent to the release of pertinent information to \_\_\_\_\_ for the purpose of providing a safe and effective area for exercise, as well as designing a safe and effective exercise program. I understand that this information will be kept confidential and only persons involved in the design and implementation of my program will be reviewing this information.

(Client's Signature)

(Date)

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