

**ST. VINCENT'S FITNESS AND WELLNESS CENTER**

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833 St. Vincent's Drive, Suite 100  
Birmingham, AL 35205  
Phone: 205-930-2823  
FAX: 930-2319

**PHYSICIAN RELEASE FORM**

MD: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

I, \_\_\_\_\_, wish to begin an exercise program at St. Vincent's  
Signature

Fitness and Wellness Center. Please list below any physical limitations or restrictions and any medications that might assist my instructors in designing an exercise program specific to my needs.

CURRENT MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I RECOMMEND THAT THE PATIENT PARTICIPATE IN AN EXERCISE PROGRAM BUT URGE CAUTION DUE TO THE FOLLOWING LIMITATIONS/RESTRICTIONS:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I **DO NOT** RECOMMEND THAT THE PATIENT PARTICIPATE IN AN EXERCISE PROGRAM.

\_\_\_\_\_

Except as stated above, I am not aware of any consideration, which under ordinary circumstances would interfere with this patient performing moderate level physical activity. He/she may exercise at his/her own risk.

\_\_\_\_\_  
Physician Signature

M.D.

\_\_\_\_\_  
Office Telephone Number

\_\_\_\_\_  
Date

Thank you for your cooperation and your commitment to your patient's overall wellness.

St. Vincent's Hospital  
Fitness and Wellness Center