Mindfulness-Based Stress Reduction (MBSR) Medical Services Release Form

Date: _____ Participant's Name: _____

Dear Provider:

Your patient is enrolling in the MBSR program: an eight week, nine session group educational program consisting of 2 ½ hour classes weekly, and a full day of guided Mindfulness practices.

Various skills of Mindfulness will be taught having to do with body centered awareness, and breathing, as it relates to focusing attention in the present moment. There will be intermittent periods of silence with guided sitting, standing, and lying down meditations, along with periods of slow, gentle stretching and movement. Your patient will be expected to dedicate 45 minutes a day towards Mindfulness home practice.

There are many years of evidenced-based research to support the value of Mindfulness practice, and its positive impact on health and well being. Please sign below indicating your support that participation in this MBSR program will not interfere with your medical management plan, and that your patient is medically stable to participate.

Please feel free to contact me with any questions about the MBSR program.

Sincerely,

Holly Nelson-Johnson, MSN, APN, FNP-BC
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This patient is medically stable to participate in the MBSR program: Yes_____ No_____

Provider Signature: _____ Please Print Name: _____

Provider Address: _____ City, State, Zip: _____

Provider Email: _____ Provider Phone: _____

I (Participant's name)_____ give permission for the MBSR program instructor to contact my medical provider if necessary; and I give permission for the medical health provider to speak with the MBSR program instructor if there are any questions.

I (Participant's name) _____ do not have a regular health care provider at this time, and will take responsibility to seek medical care if/when it is necessary.

Participant Signature: _____Please Print Name: _____