BAC/RAC Customer Service Department
21 Goodway Drive
Rochester, NY 14623
866-538-8201 Phone

Patient's Name__________________________________ **Date of Birth**______________________ **Date of Request**______________________

I authorize Dr.__________________________ to release information to the Buffalo / Rochester Athletic Club for the purpose of determining safe participation in an exercise program, which may consist of cardiovascular exercise, resistance training, stretching, and other forms of physical activity at the club.

The **significant physical disability** that I feel needs to be addressed for the sole purpose of cancelling membership contract to the health club that I currently belong to is _________________________________.

This authorization is valid for this request and any future treatment of the conditions described above until cancelled by the patient. Per the physician's instructions, the patient may cancel this authorization at any time. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the club and is no longer protected by HIPAA.

Patient Signature ____

****THE FOLLOWING INFORMATION IS TO BE PROVIDED BY A PHYSICIAN ONLY****

1. Diagnosis of injury / illness ____

2. This patient has been under my care since____

3. Is there a **significant physical disability** that will cause any limitations to the following cardiovascular activities? If yes, what limitations and for what period of time are they prohibited from participating in that type of activity?

Bicycling Y N ____For how long? __________________________

Walking Y N ____For how long? __________________________

Stair Climbing Y N ____For how long? __________________________

Running Y N ____For how long? __________________________

Elliptical Machines Y N ____For how long? __________________________

Aerobic Classes Y N ____For how Long? _________________________

4. Is there **a significant physical disability** that will cause any limitations to weight bearing exercises? Y _____________ N _____________
If yes, what are the limitations to the following areas and what time period are they prohibited from participating in that type of activity?

Upper Body Movements Y N _________________ _______For how long? ____

Lower Body Movements Y N ________________________ For how long? ____

5. Are there any specific heart rate limitations Y N If yes, what ____

Doctor's recommended treatment and continued use of the facilities____

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Please print: Physician's Name: ____

Physician's telephone #_______________________________ Fax # _____________________________

Authorized Physician's Signature____ **Date Signed** ______________

Please submit completed form to the Buffalo Athletic Club along with your membership card, and a $25.00 payment for cancellation / processing fee. You may submit this payment in a form a personal check, money order or credit card

Credit Card # _______________-_______________-_______________-_______________ **Exp. Date:** _______________________