**Healthcare Professional Release Form**

**(Optional)**

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| --- | --- |
| Date: |  |
| Participant Name (Printed): |  |
| Participant Signature: |  |

**Participant Consent and Authorization**

By signing this form, I authorize the healthcare professional below to release to Beverly Swann, PhD student and primary researcher for the Muscle Relaxation Study, health information about, and limited to, my ability to safely take part in the Muscle Relaxation Study. I may revoke, in writing, this Consent and Authorization at any time. This Consent and Authorization will expire one year from the above date.

**Healthcare Professional Release and Recommendations**

Your patient/client, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant name), has volunteered to participate in a research study on the use of muscle relaxation for adults who have co-occurring non-specific chronic low-back pain (nsCLBP) and post-traumatic stress disorder (PTSD).

Participants will be trained in one of two muscle relaxation techniques and will be asked to practice that technique for four weeks. The two techniques are Trauma Releasing Exercises (TRE) and Progressive Muscle Relaxation (PMR). TRE involves gentle physical movement which is the equivalent of mild physical exercise. The movements can be modified for individuals who have injuries or balance issues, with a constant goal of *no pain*. PMR is done in a seated position and involves systematically tensing and releasing of muscle groups. It has no known side effects. For more information, please see the study website: [www.cygnustransformations.com/research-central/muscle-relaxation-study/mr-study-professionals/](http://www.cygnustransformations.com/research-central/muscle-relaxation-study/mr-study-professionals/)

By completing this form, you are not assuming any responsibility for this research study. Please identify the recommendations or restrictions you may have for this participant below:

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| --- | --- |
|  | I am not aware of any contraindications for participation in this study. |
|  | I release the above-named participant for participation in this study, with the following restrictions: |
|  | The above-named participant should NOT participate in this study. |

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| --- | --- |
| Date: |  |
| Healthcare Professional Name (Printed): |  |
| Healthcare Professional Signature: |  |
| Address: |  |
| City/State/Zip: |  |
| Phone: |  |
| Fax: |  |