DASA Meditation

Release to Learn Meditation

Therapist / Psychologist / Psychiatrist should complete and sign this document.

Name of patient:

Name of treating professional:

Address: City:

Phone: Work: Cell (emergency use only):

AUTHORIZATION

☐ I verify I am currently treating this patient and that they are over the age of 18.

With my signature below, I approve of my patient learning the DASA Meditation Technique.

Therapist / Physiologist / Psychiatrist – Please fill out the information below.

Name_____Title_____

Authorization Date: _____

Comments: