**INFORMED CONSENT FOR LYMPHATIC BREAST CARE**

My health care practitioner has explained the purpose of lymphatic drainage of the breast and has answered all of my questions.

I understand the nature of the treatment and I give permission to Allyssa Bedard, Licensed Massage Therapist to perform Lymphatic Breast Care.

I understand that I am encouraged to give feedback to the therapist, and may discontinue the session at any time, without any questions asked, by verbally informing my health care practitioner.

_____(Print Name)

_____(Signature)

_____(Date)