

*Arizona Injury Medical Associates, P.L.L.C.*  
*Physiatry Care*

**Information, Instructions, Consent for your IME, Release of Records**

I understand that I am here for an independent medical examination (IME), which means the doctor performing the evaluation is neither treating me nor an employee of whomever requested the IME (insurance company, third party administrator, attorney, governmental agency, employer or physician). I understand the purpose of the independent medical examination is to provide a thorough, objective evaluation of the specific condition(s) related to my injury or illness which is in question, as well as prior or subsequent conditions that might affect it, and to answer whatever questions the requesting party has. This sheet outlines the process, my rights and responsibilities.

The IME is **not** a comprehensive examination. I understand it will **not** provide advice or treatment to me or substitute for evaluation or treatment by my regular treating doctor. I understand a patient/physician relationship is not established between the evaluating physician and me. Accordingly, there is no patient/physician privilege associated with this evaluation. Usually a written report will be prepared summarizing today's evaluation and sent to the requesting party. If I would like a copy of that report, I will contact them.

I understand that generally the evaluation will begin with obtaining a history of how my problem began and what evaluation or treatment has been rendered since, utilizing information I provide verbally and/or on the history forms, as well as that contained within whatever records may be available for review. I will then be asked about my current symptoms and record a relatively brief past medical history and other information such as my work status, etc. All information, which I provide, may be included in the report.

After the interview, a physical examination of the relevant body part(s) will be conducted. I understand that I need not perform any maneuver I feel might cause injury or worsening of my symptoms, and will immediately inform the examiner if anything he is doing is causing excessive discomfort so it can be stopped right away. I understand some pain, stiffness or other symptoms are produced in most physical examinations of this sort and are helpful in understanding the condition. The IME, however, is not intended to cause injury or excessive pain. I understand that in order to avoid that, I must fulfill my responsibility to inform the doctor if there is something I cannot do, a certain test is causing too much discomfort, etc.

I also understand that I will be permitted to have a chaperone present during the physical examination. It may be necessary to obtain additional x-rays or other diagnostic tests in order to answer certain questions. These may be performed here or at another facility.

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1. I hereby authorize Demitri A. Adarmes, M.D. to perform an impairment and/or independent medical evaluation upon me and to release that information and the results of this IME (verbally or in writing) to any entity who has requested the IME.
  
2. I understand that this physician will not provide treatment to me and that a physician/patient relationship will not be created.
  
3. I hereby authorize any physician, hospital, medical attendant, psychiatrist, psychologist, mental health counselor, or the custodian of any file or records pertaining to me to furnish Demitri A. Adarmes, M.D., any and all documents or records in their possession with respect to any illness, injury, medical history, examination, consultation, prescription, or treatment and to allow Demitri A. Adarmes, M.D. to see or copy any x-rays or records or reports relating to me. This authorization includes the release of all tests, test results, opinions, records, documents, and other information relating to any psychiatric, psychological or other mental health examination, treatment, including treatment for alcohol or drug use, counseling or evaluation, relating to me. I hereby waive any privilege or right to have this information kept confidential, and I hereby consent to the release of this information to the above upon presentation of this authorization or photocopy, thereof.

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Signature

Date

Printed Name

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Witness Signature

Date

Witness Printed Name