Date: [Insert Date]

To: [Custodian of Records/Doctor Name]
Facility Name: [Insert Facility Name]
Address: [Insert Address]

RE: AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR INDEPENDENT MEDICAL EXAMINATION (IME)

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Social Security Number: [Insert SSN - Optional]
Date of Injury/Incident: [Insert Date]

To Whom It May Concern:

I hereby authorize [Insert Facility Name] to release my complete medical records and health information to the following examining physician or entity for the purpose of an Independent Medical Examination:

Recipient Name/Entity: [Insert IME Doctor or Insurance Company Name]
Address: [Insert Address]
Phone Number: [Insert Phone Number]

Information to be Released:

- Complete medical charts and clinical notes
- Diagnostic imaging reports (MRI, CT, X-Ray)
- Laboratory results
- Physical therapy and rehabilitation records
- Operative reports
- Pharmacy and medication records

This authorization is valid for the following period: [Insert Time Frame, e.g., 90 days]. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

A photocopy or electronic version of this signed authorization shall be considered as valid as the original.

Sincerely,

_____

[Patient Signature or Legal Representative]

Printed Name: [Insert Name]
Relationship to Patient: [Insert Relationship if applicable]