[Your Name/Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email]

[Date]

[Doctor's Name]
[Facility Name]
[Address]
[City, State, Zip Code]

**RE: Notice of Intent to Audio Record Independent Medical Examination**

Patient Name: [Examinee Name]
Date of Birth: [DOB]
Date of Examination: [Date]
Claim/Case Number: [Number]

Dear Dr. [Doctor's Last Name],

Please be advised that pursuant to [State Statute/Court Rule/Agreement], the Independent Medical Examination of [Examinee Name] scheduled for [Date] at [Time] will be audio recorded in its entirety.

The recording will be conducted by [the examinee / a legal representative / a professional videographer] using a non-obtrusive recording device. The purpose of this recording is to ensure an accurate record of the history taken and the physical tests performed during the evaluation.

This notice is provided to ensure there is no disruption to the examination process. The recording will not interfere with your ability to conduct a thorough evaluation. We request that you acknowledge receipt of this notice and confirm that your office is prepared to proceed with the examination under these conditions.

Thank you for your cooperation in this matter.

Sincerely,

[Signature]

[Printed Name]
[Title/Capacity]

cc: [Opposing Counsel Name/Insurance Adjuster Name]