IME Consent Form

I, _____ *(name of employee)*, hereby authorize *agent* to release information to my employer representative(s) about my abilities and limitations with respect to my job duties.

I also hereby authorize my doctor(s), specialist(s), or other health care practitioners:

_____

First & Last Name Phone Number

_____

First & Last Name Phone Number

to consult with, receive and release to *agent* any and/or all medical, vocational, or psychological information, as well as any test results for the purpose of providing and/or clarifying information in order to support the workplace accommodation process.

agent shall maintain the confidentiality of this information, and will not disclose it to a third party without my written consent, except where disclosure is required by law.

I declare that my consent has been given voluntarily. I understand that I may withdraw my consent at any time. Unless previously revoked by me in writing, this consent will expire 180 days from the date this form is signed.

Name of Employee: _____
(Print Name)

_____, _____
(Signature) (Date: yyyy-mm-dd)

Name of witness: _____
(Print Name)

_____, _____
(Signature) (Date: yyyy-mm-dd)