

I.M.E.



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AUTHORIZATION FOR INFORMATION RELEASE

This form (or photographic copy of it) will authorize you to give to Independent Medical Evaluations, Inc. any information you have with reference to the medical history, attendance, hospitalization, or advice given to, the undersigned, or his or her legal representative.

Name: _____

Signature/Relationship Date

Witness Date

Fax or Mail to IME, Inc.