CONSENT FOR INDEPENDENT MEDICAL EXAMINATION

My signature below affirms that I, or the parent or guardian of such individual, have read, understand, and consent to the following:

1. My appointment with Dr. Charles Timothy Floyd is an independent medical examination (IME). The IME is related to my claim or case. Dr. Floyd will perform an exam of the area(s) of my body that were injured, or near the injury. I grant Dr. Floyd permission to conduct this IME.

2. I have the right to decline to participate in any part of the IME with which could cause me increased pain or harm, now or later.

3. This appointment was requested and scheduled by a third party.

4. I am under no financial obligation to Dr. Floyd for today's IME or any subsequent reports that may follow. This IME is free to me.

5. The IME performed by Dr. Floyd does not create a doctor-patient relationship. Dr. Floyd cannot directly give me medical advice or recommendations; he is not my treating doctor.

6. Dr. Floyd's opinions will be in the IME report, and I am entitled to receive a copy of Dr. Floyd's report. I can obtain the report directly from the third party that requested this IME. Dr. Floyd cannot provide a copy of the report directly to me or my representative.

7. Any information obtained by Dr. Floyd from this IME will be used and disclosed as discussed in the Authorization form attached to this Consent document (on the next page).

8. WOMEN: I have the right to have a chaperone with me during the physical examination portion of the IME. Please circle one of the following:

   I want to have a chaperone to be with me during the physical exam of the IME.

   I do not want to have a chaperone with me during the physical exam of the IME.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

_____

Name and Signature of Guardian or Parent, if applicable

AUTHORIZATION FOR RELEASE OF RECORDS
(Required by HIPAA)

Name: _____ Date of Birth: _____

Third Party: _____
Name

I am the individual granting authorization (or the authorized representative).

Third Party (identified above) requires that I obtain certain tests, exams, or other care for certain purposes through an "Independent Medical Examination" (IME). I hereby authorize Dr. Charles Timothy Floyd ("Dr. Floyd") to disclose the following information to Third Party for purposes of the IME:

- ☐ All medical records, including history, tests, physical exam records or results and opinions, created or ordered by Dr. Floyd related to the IME, now or in the future.

- ☐ Response to questions or inquiries from the Third Party about Individual's medical condition or any of the foregoing exams, tests, results or opinions. This includes future correspondence.

- ☐ Other (describe): _____

I understand that I may revoke this Authorization at any time prior to the date that Dr. Floyd performs the IME. I understand that the IME is rendered for the purpose of disclosing the health information, described above, to Third Party and that Dr. Floyd is relying on this Authorization to perform the IME. Accordingly, Dr. Floyd may condition the IME on this Authorization, and I may not revoke this Authorization after Dr. Floyd has begun performing the IME. I waive and release Dr. Floyd from any and all claims or causes of action against Dr. Floyd relating to disclosures pursuant to this Authorization.

I understand that I can change my mind about this authorization at any time up until the IME begins and cancel (i.e., revoke) this authorization. If I do not authorize Dr. Floyd to send this information to Third Party, he probably will not proceed with the IME, because HIPAA requires that I grant him permission to do so. I understand that I cannot change my mind after the IME begins because Dr. Floyd is relying on this authorization to perform the IME. I waive and release Dr. Floyd from any and all claims or causes of action against Dr. Floyd relating to disclosures pursuant to this authorization.

I hereby authorize Dr. Floyd to disclose the information described above to Third Party via e-mail, text, other electronic means, or as requested or required by Third Party. I understand that such means may not be secure. I understand that this Authorization is effective on the date signed and shall continue for the longer of one (1) year thereafter, or until Individual's relationship with Third Party ends for any reason (e.g., termination of employment, termination of case, etc.). I understand that information disclosed pursuant to this Authorization may be redisclosed by Third Party or others receiving the information and no longer protected by HIPAA or other appliable laws or regulations.

_____ _____
Signature Date

_____
If signed by authorized representative, describe relationship to Individual