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MEDICAL-LEGAL EVALUATION CONSENT & RELEASE FORM

Client Name: _____

I, _____, consent to and authorize Dr. Mark Oakley to assess and evaluate my emotional and psychological status and to answer the referral questions related to my worker's compensation claim at the request of _____ (The insurance company for my Employer or in Dr. Oakley's capacity as my Panel Qualified Medical Examiner [PQME]).

I understand that Dr. Oakley has been retained by and is acting at the request of the insurance company for my Employer or in Dr. Oakley's capacity as my Panel Qualified Medical Examiner (PQME), _____, and that Dr. Oakley will provide information to _____ as authorized by the attached Authorization For Disclosure. This information may be provided verbally and/or in writing and may include the following: Dr. Oakley's opinion regarding my mental status and whether or not in his opinion, my claim is compensable per worker's compensation guidelines, Dr. Oakley's opinion regarding the need for treatment and whether or not my emotional status is work-related or due to non-industrial factors. Dr. Oakey's evaluation may discuss whether or not non-industrial factors play a role in any disability, whether or not any disability can be apportioned to pre-existing conditions or non-industrial causes and the reasons why he arrived at these options.

I understand that in addition to the above, Dr. Oakley is required or permitted to disclose information in the following circumstances:

- If Dr. Oakley has a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
- If I communicate a serious threat of bodily injury to an identifiable victim or if Dr. Oakley has a reasonable belief that I may be a danger to myself, another or the property of another.
- As required pursuant to a legal proceeding or as otherwise required by law.

I understand that while Dr. Oakley may make recommendations regarding my treatment as a result of my evaluation, that Dr. Oakley will assume no role in my treatment and that he will not provide psychological counseling or follow-up services to me. I understand that there is no psychotherapist-patient relationship between Dr. Oakley an myself. I understand that this consent is not revocable and that the consequences of failure to cooperate and undergo the evaluation and assessment may result in the delay or denial of my worker's compensation claim.

I understand that I have the right to receive a copy of this authorization. This authorization shall become effective on _____ and will expire in one year. A photocopy or facsimile of this form is to be considered as valid as the original. I HAVE READ THIS CONSENT FORM IN IT ENTIRETY AND FULLY UNDERSTAND ITS CONTENTS. I HAVE HAD THE OPPORTUNITY TO RECEIVE CLARIFICATION. I CONSENT AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Signature: _____ Date: _____