DRIVER REHABILITATION SERVICES, P.A.
DRIVER EVALUATION AND TRAINING
CONSENT AND RELEASE OF INFORMATION FORM

I, _____ understand that I am taking a comprehensive driving evaluation through Driver Rehabilitation Services, P.A., McLeansville, North Carolina, for the purpose of determining my ability to drive a motor vehicle. The evaluation will consist of a clinical assessment, vehicle and equipment assessment and behind the wheel assessment. I consent and agree to participate in all of the evaluation procedures constituting the program. I agree to abide by the results obtained. These recommendations may include vehicle and adaptive equipment requirement, re-evaluation, or requests for further medical treatment or consultations. I am solely responsible for completing these recommendations, and understand that documentation of my ability to drive a motor vehicle will be contingent on my completion of all recommendations given by Driver Rehabilitation Services.

I understand that driving a motor vehicle on public roads is a privilege granted me by NC DMV. I understand that safely driving a motor vehicle requires good physical control of the vehicle, as well as good visual, perceptual, and cognitive skills by the driver in order to react to the changing traffic environment. I understand that my medical diagnosis of _____ may impair my driving ability. I am voluntarily submitting to a driver assessment in order to ascertain if I may have any physical, mental, visual, cognitive and/or perceptual impairment that my impede my ability to drive a motor vehicle safely.

I authorize Driver Rehabilitation Services, P.A. to release all information of my driver evaluation and training program to the North Carolina Division of Motor Vehicles, or to the state in which I reside. I consent to allow my therapist and physician to discuss the results directly with the state's DMV upon their request or for clarification regarding my case. Information may also be released to my physician, Vocational Rehabilitation counselor, Independent Living counselors, the rehabilitation engineer, or myself (if applicable).
Others:
Should I fail the battery of physical, cognitive, visual-perceptual tests, and/or behind the wheel assessment, the NC DMV Medical Branch will be notified. I give this consent with awareness that such disclosure may results in the revocation of my license to drive or prevent me from obtaining such a license in the future. I am aware that the NC DMV Medical Branch has the authority to make final decision regarding my driving status. If I pass the drivers evaluation, I understand that I must consult with my physician regarding my test results prior to operating a motor vehicle independently or undergoing driver training.

I further consent to and authorize that information from my medical records relating to my identity; diagnosis, prognosis or treatment may be released to Driver Rehabilitation Services, P.A. I understand that the purpose or need for this disclosure is to determine my safety to drive.

I further agree and do hereby release Driver Rehabilitation Services, P.A., my evaluator(s) and my physicians from any claims of any nature arising out of my participation in the driver assessment and training service.

Each evaluation and training session will be a billable expense. I understand that I may be responsible for all or part of the bill if my other funding sources refuse payment. This includes third party payors who may indicate that additional payment is not required because of preferred provider status. If pre-authorization has not been obtained, I understand that I am responsible for full payment when services are rendered.

_____ _____
Signature of Client Date Driver Evaluator/Trainer Date
(understanding the above information)

_____
Signature of Parent/Guardian, Relative of Other Date
(witnessed the explanation of this contract; signature optional)