Date: [Insert Date]

To: [Recipient Name/Organization Name]
From: [Provider Name, Title]
Facility: [Clinic/Practice Name]
Phone: [Phone Number]

RE: Medical Authorization for [Patient Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

The above-named patient was under my care following a positive COVID-19 diagnosis on [Date of Positive Test].

I have evaluated the patient and confirm that they have met the clinical criteria for recovery and are no longer considered contagious according to current public health guidelines. As of [Date of Return], the patient is medically cleared to:

- Return to work/school.
- Resume normal daily activities.
- Participate in physical exercise/sports [with/without] restrictions.

Special Instructions or Restrictions:
[Insert specific restrictions or "None"]

Please feel free to contact my office if you require further information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP/PA]
[License Number/NPI]