Patient Authorization for Release of Medical Information (FMLA)

Patient Name: [Full Name]

Date of Birth: [Date of Birth]

Social Security Number (Optional/Last 4): [SSN]

To: [Healthcare Provider/Clinic Name]

Address: [Provider Address]

I hereby authorize the healthcare provider named above to release medical information regarding my condition to my employer, **[Employer Name]**, and its designated representatives or leave administrators.

Information to be Released:

The information requested is limited to what is necessary to process my request for leave under the Family and Medical Leave Act (FMLA). This includes, but is not limited to:

- Date the serious health condition commenced.
- Probable duration of the condition.
- Appropriate medical facts regarding the condition as it relates to my ability to perform my job functions.
- Estimated frequency and duration of episodes (for intermittent leave).

Purpose of Disclosure:

The purpose of this disclosure is to determine my eligibility for FMLA leave and to satisfy the certification requirements of my employer's leave policy.

Expiration and Revocation:

This authorization will expire on [Date or Event] or one year from the date of signature, whichever occurs first. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

Right to Refuse:

I understand that I may refuse to sign this authorization. However, I also understand that if I refuse to provide the necessary medical certification, my request for FMLA leave may be delayed or denied.

Signature of Patient: _____

Date: _____

Patient Address: [Your Street Address, City, State, Zip]

Patient Phone Number: [Your Phone Number]