Date: [Insert Date]

To: [Medical Clinic/Physician Name]
Address: [Clinic Address]
Phone/Fax: [Clinic Phone/Fax Number]

RE: Authorization to Release Information for FMLA Certification

Patient Name: [Employee Name]
Date of Birth: [Employee Date of Birth]

To Whom It May Concern,

I hereby authorize [Name of Clinic/Physician] to release the medical information necessary to complete the attached "Certification of Health Care Provider" form for my Family and Medical Leave Act (FMLA) request.

This authorization is limited to providing the information required to verify a serious health condition and the duration of the requested leave. It does not authorize the release of my entire medical record or any information unrelated to the specific condition for which leave is being sought.

Please provide the completed certification form to my employer's Human Resources department at:

Company Name: [Company Name]
Attention: [HR Contact Name]
Fax/Email: [HR Fax Number or Email Address]

This authorization will expire upon the processing of this specific FMLA request, unless I revoke it in writing sooner.

Thank you for your assistance.

Sincerely,

[Employee Signature]

_____
[Employee Printed Name]