[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Doctor's Name or Healthcare Facility Name]
[Department, e.g., Medical Records Department]
[Facility Address]
[City, State, Zip Code]

RE: Authorization for Release of Medical Information for FMLA Certification

To Whom It May Concern,

I am writing to formally authorize the release of my medical records to my employer, [Employer Name], for the sole purpose of processing my request for leave under the Family and Medical Leave Act (FMLA).

Patient Information:
Full Name: [Your Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional/Last 4 digits): [XXX-XX-XXXX]

Information to be Released:
Please provide the medical certification and documentation necessary to confirm a "serious health condition" as defined by FMLA. This includes information regarding the date the condition commenced, the probable duration, and relevant medical facts regarding my ability to perform my job functions.

Recipient Information:
Please send the requested documentation to:
[Name of HR Representative/Department]
[Company Name]
[Company Address/Fax Number/Email]

This authorization is valid for [Number] days from the date of signing or until my FMLA application is processed. I understand that I have the right to revoke this authorization in writing at any time.

Thank you for your prompt attention to this matter.

Sincerely,

_____

[Your Signature]

[Your Printed Name]