AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Employee Name: _____
Date of Birth: _____
Employee ID: _____

To: (Name of Healthcare Provider/Medical Facility)
Address: _____
Phone/Fax: _____

I hereby authorize the above-named healthcare provider to release medical information regarding my health condition to my employer, **[Company Name]**, and its designated human resources or leave administration representatives.

Scope of Release:
This authorization is limited to information necessary to process my request for leave under the Family and Medical Leave Act (FMLA). This includes, but is not limited to:

- Medical certification of a serious health condition.
- Date the condition commenced and its probable duration.
- Information regarding my ability to perform essential job functions.
- Applicable treatment schedules or recovery periods.

Purpose:
The purpose of this disclosure is to verify my eligibility for FMLA leave and to determine any necessary reasonable accommodations for my return to work.

Expiration:
This authorization will expire one year from the date of signature or upon the conclusion of my current FMLA leave period, whichever occurs first.

Rights:
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. I understand that my employer may not condition my employment on whether I sign this authorization; however, failure to provide sufficient medical certification may result in the denial of FMLA leave.

Signature of Employee: _____

Date: _____