Authorization to Release Medical Information

Date: [Insert Date]

To: [Insert Name of Healthcare Provider/Clinic]
Address: [Insert Provider Address]
Phone/Fax: [Insert Provider Contact Info]

Re: Patient Name: [Insert Employee Full Name]
Date of Birth: [Insert Date of Birth]
Social Security Number (Last 4 digits): [Insert Last 4 Digits]

I hereby authorize [Insert Name of Healthcare Provider] to release medical information regarding my current health condition to my employer, [Insert Company Name], specifically to the [Insert Department, e.g., Human Resources Department].

This authorization is limited to information necessary to process my request for leave under the Family and Medical Leave Act (FMLA). The specific information to be disclosed includes:

- The date the serious health condition commenced.
- The probable duration of the condition.
- Appropriate medical facts regarding the condition as it pertains to my ability to perform my job functions.
- The expected duration and schedule of leave (intermittent or continuous).

I understand that this authorization is voluntary. I also 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. This authorization will expire one year from the date of my signature or upon the conclusion of my FMLA leave, whichever occurs first.

A photocopy or fax of this signed authorization shall be as valid as the original.

Employee Signature: _____

Print Name: [Insert Employee Name]

Date: _____