Date: [Date]

To: [Name of Healthcare Provider/Clinic]
Address: [Clinic Address]
City, State, Zip: [City, State, Zip Code]

RE: AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR FMLA PURPOSES

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Social Security Number (Optional): [Last 4 Digits]

To Whom It May Concern,

I hereby authorize [Name of Healthcare Provider/Clinic] to release and disclose my protected health information to my employer, [Employer Name], and its designated leave administrators, specifically for the purpose of processing my request for Family and Medical Leave Act (FMLA) benefits.

Information to be Released:
This authorization is limited to the information required on the "Certification of Health Care Provider" form, including:
- Date the serious health condition commenced.
- Probable duration of the condition.
- Relevant medical facts regarding the condition as it relates to my ability to perform job functions.
- Requirements for intermittent leave or a reduced work schedule.

Purpose of Disclosure:
To document a serious health condition in support of an FMLA leave request.

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

Right to Revoke:
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 this authorization.

Signature:

_____
[Patient Signature]

Printed Name: [Patient Printed Name]