Authorization for Release of Health Information

Employee Name: _____

Date of Birth: _____

Employee ID: _____

1. Authorized Provider:
I hereby authorize [Name of Healthcare Provider/Clinic] to release my protected health information to [Name of Employer/Third Party Administrator].

2. Scope of Information:
The information to be disclosed is limited to the medical certification required to process my request for leave under the Family and Medical Leave Act (FMLA). This includes information regarding my serious health condition, the duration of the condition, and any work restrictions or clinical requirements necessary to determine FMLA eligibility.

3. Purpose:
The purpose of this disclosure is to process and administer my request for FMLA leave and/or related disability benefits.

4. 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.

5. Rights:
- I understand that I have the right to revoke this authorization in writing at any time.
- I understand that signing this authorization is voluntary; however, failure to provide medical certification may result in the denial of FMLA leave.
- I understand that once information is disclosed to the employer, it may no longer be protected by the HIPAA Privacy Rule, though it remains subject to FMLA confidentiality requirements.

Signature: _____

Date: _____