EMPLOYER FMLA MEDICAL INFORMATION RELEASE CONSENT

Date: [Date]

To: [Healthcare Provider Name]
Address: [Healthcare Provider Address]
Phone/Fax: [Healthcare Provider Phone/Fax]

Employee Name: [Employee Full Name]
Date of Birth: [Employee Date of Birth]

I, [Employee Full Name], hereby authorize my healthcare provider named above to release medical information to my employer, [Company Name], specifically to the Human Resources Department or the FMLA Leave Administrator.

Scope of Authorization:
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:

- Confirmation of a serious health condition.
- The date the condition commenced and its probable duration.
- The medical necessity for leave or a reduced work schedule.
- Functional limitations or restrictions affecting my ability to perform essential job functions.

Purpose:
The purpose of this disclosure is to verify my eligibility for FMLA leave and to facilitate the certification process as required by company policy and federal law.

Expiration:
This authorization will expire one year from the date of signing 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 in reliance on it. I understand that my employer cannot condition my treatment or payment on whether I sign this authorization; however, failure to provide sufficient medical certification may result in the denial of my FMLA leave request.

Signature: _____
Date: _____

Printed Name: [Employee Full Name]