DATE: [Date]

TO: [Patient Name]

PATIENT DOB: [Date of Birth]

RE: Authorization to Release Information for FMLA Verification

Dear [Patient Name],

Our office has received a request from your employer, [Employer Name], to provide medical verification for your Family and Medical Leave Act (FMLA) application.

Before we can complete and submit these documents, we require your written authorization to release your private medical information. Please sign the attached "Release of Information" form and return it to our office via mail, fax at [Fax Number], or in person.

Please note that our clinic charges a fee of $[Amount] for the administrative processing of FMLA paperwork. This fee must be paid before the forms are sent to your employer.

Once we receive your signed authorization and the processing fee, we will complete the forms within [Number] business days.

If you have any questions, please contact our medical records department at [Phone Number].

Sincerely,

[Name of Clinic Representative]
[Title]
[Clinic Name]