DATE: [Date]

TO: [Healthcare Provider Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]

RE: AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR FMLA

Patient Name: [Employee Name]
Date of Birth: [DOB]
Employee ID: [ID Number]

Dear [Healthcare Provider Name],

I am writing to formally request that you complete the attached "Certification of Health Care Provider" form in support of my application for leave under the Family and Medical Leave Act (FMLA).

By signing this letter, I hereby authorize you to release medical information to my employer, [Company Name], specifically regarding the following:

- The commencement date of the serious health condition;
- The probable duration of the condition;
- Relevant medical facts regarding the condition as they relate to my ability to perform my job functions;
- The estimated frequency and duration of any required treatments or intermittent leave.

This authorization is limited to information necessary to verify my eligibility for FMLA leave. Please return the completed forms by [Deadline Date] via [Fax Number/Email/Postal Address].

Thank you for your assistance in this matter.

Sincerely,

[Employee Signature]

[Employee Printed Name]
[Phone Number]