

Date: [Date of Issue]

To Whom It May Concern,

Patient Name: [Patient Full Name]

Date of Birth: [Date of Birth]

Date of Assessment: [Date of Telehealth Visit]

This letter serves to certify that the individual named above has undergone a clinical assessment via telehealth regarding their quarantine status for [Condition, e.g., COVID-19].

Based on the clinical evaluation, review of reported symptoms, and adherence to current public health guidelines, the patient has met the following criteria for release from quarantine:

- Completion of the required isolation/quarantine period of [Number] days.
- Improvement in respiratory symptoms (if applicable).
- Afebrile (fever-free) for at least [Number] hours without the use of fever-reducing medications.

As of [Clearance Date], the patient is clinically cleared to return to work, school, and other normal activities without restrictions.

If you have any questions or require further verification, please contact our office at [Phone Number].

Sincerely,

[Provider Signature/Name]

[Provider Title]

[Clinic/Organization Name]

[License Number]