[Date]

[Doctor Name]
[Medical Practice Name]
[Address]
[City, State, Zip Code]

RE: Authorization for Release of Medical Information

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

Dear [Doctor Name],

Our employee, [Employee Name], is currently seeking to return to work following a medical leave of absence. To ensure a safe and successful transition, we require a formal assessment regarding their fitness for duty.

We are requesting medical records or a clinical summary specifically pertaining to the employee's ability to perform the essential functions of their job, which are outlined in the attached job description. Please provide information regarding:

- The date the employee may return to work.
- Any functional limitations or physical restrictions required.
- The expected duration of these restrictions.
- Any necessary workplace accommodations.

Please note that we are not requesting information prohibited by the Genetic Information Nondiscrimination Act (GINA) or medical history unrelated to the employee's current ability to perform their job duties.

Attached is a signed medical release form from the employee authorizing the disclosure of this information to [Company Name].

Please send the requested documentation to [Contact Name/Department] via secure fax at [Fax Number] or email at [Email Address].

Thank you for your assistance.

Sincerely,

[Your Signature]
[Your Name]
[Your Title]
[Company Name]