# CONSENT FOR RELEASE OF FITNESS FOR DUTY MEDICAL RECORDS

**Employee Name:** _____

**Employee ID:** _____

**Date of Birth:** _____

**TO:** (Name of Medical Provider/Clinic)
**Address:** _____
**City/State/Zip:** _____

I hereby authorize the medical provider named above to release my medical records and information specifically related to my Fitness for Duty evaluation to:

**RECIPIENT:** (Name of Employer/Company Name)
**Attention:** (Name of HR Representative or Department)
**Address:** _____

**Information to be Released:**

- Results of the Fitness for Duty examination performed on (Date: _____).
- Specific functional limitations or work restrictions, if any.
- Estimated date of return to full duty.
- Recommendations regarding workplace accommodations.

**Purpose of Disclosure:**
To determine my ability to perform the essential functions of my job position and to evaluate any necessary workplace accommodations.

**Authorization Terms:**

- I understand that this authorization is voluntary.
- 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.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- This authorization will expire 90 days from the date of signing unless otherwise specified here: _____.

**Signature of Employee:** _____

**Date: _____**