Generations of Excellence, Caring for Women.

FMLA Authorization to Release Information via Fax or Email

Employee Information

Name: ____

Email: ____ Phone: ___________________________

Authorization to Release Information

I, the undersigned, authorize the release of my medical and/or FMLA-related information to the following individual or organization:

Recipient Information

Recipient Name/Organization: __________________________________ Fax Number: _______________________

Contact Person (if applicable): ___________________________________ Email: ____________________________

Purpose of Disclosure

This information is to be used for:

☐ FMLA Certification/Recertification ☐ Leave Request Verification ☐ Return-to-Work Clearance

Information to be disclosed

I authorize the release of:

☐ Medical Certification Form (I.E. WH-380-E or WH-380-F) ☐ Fitness for Duty Documentation

☐ Medical Records Related to Leave (Could include history of STDs, HIV, AIDS, and psychological records)

I understand that fax and email are not secure methods of communication, and there is a risk that my information could be intercepted or accessed by unauthorized individuals. I acknowledge and voluntarily consent to the use of these methods, accepting the associated risks.

Expiration and Revocation

This authorization will remain in effect until (check one):

☐ 90 days from the date of signature ☐ Completion of the FMLA process

I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken based on this authorization.

Signature

Patient Signature: ____ Date: ________________

Witness (if required): _____________________________________ Date: ________________

For your convenience, please email the request to:
medrec@cheyenneobgyn.com or fax it to 307.638.9474