

## FMLA MEDICAL RELEASE

*This form should be completed by employees wishing to have their treating physician send all required paperwork directly to the Commission Office.*

EMPLOYEE NAME: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

I authorize my health care provider, physician, or hospital to disclose any related information regarding my history, physical, or mental condition to clarify or authenticate my FMLA request to HOUSTON COUNTY COMMISSION in order to process my request for leave under FMLA. This release expires 12 months from the date below.

\_\_\_\_\_  
Patient Signature (or Parent/Guardian)

\_\_\_\_\_  
Date

A copy of this release and the attached certification form for the above named patient may be sent directly to on or before \_\_\_\_\_:

Sheri Thompson  
Human Resources  
P.O. Box 6406  
Dothan, AL 36301  
Fax: 334-677-4779  
Phone: 334-677-4778