Polk State College
Family Medical Leave Act
RELEASE AUTHORIZATION FOR MEDICAL INFORMATION

I, _____ **,** certify that I have requested leave under the Family and Medical Leave Act (FMLA) from Polk State College. I have asked for this Leave because of the medical condition of _____.
(Name of Seriously Ill: Self or Family Member)

I hereby authorize and request the release of any and all information to my employer, Polk State College, in order for them to obtain the certification required and permitted by the Family and Medical Leave Act of 1993 to grant me this leave.
A photocopy of this authorization is to be considered as valid as the original. I Hereby certify and direct each and every physician or other health care provider to Whom this is sent to cooperate by answering, in full, all of the college's questions Relating to this requested leave.

_____ _____
Employee Signature PID# Date

_____ _____
Signature of Human Resources Witness Date