AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY
(ORR CHECK)

I, _____ authorize the following CMHSPs Office of Recipient Rights
(print full name)
to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law:

☐ BABHA ☐ SCCMHA ☐ CMHCM ☐ GIHN ☐ Benzie County ☐ Oakland County
☐ Wayne County ☐ Northern Lakes ☐ Other _____ ☐ _____

I, _____ release the aforementioned Office of Recipient Rights, its
(print full name)
officers, its agents and its employees for disclosing the information requested by me and I shall indemnify and hold harmless should any claims, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

1. _____ Dates employed: _____ to _____
2. _____ Dates employed: _____ to _____
3. _____ Dates employed: _____ to _____
4. _____ Dates employed: _____ to _____

_____ _____ _____
Applicant's Signature **Date** **Previous Names Used (print)**

_____ _____ _____
Witness Signature **Date** **Applicant's Birth Date**

INFORMATION TO BE SENT TO:

_____
Provider/Consumer

_____
Street Address

_____
City **State** **Zip Code** **Fax**

RIGHTS OFFICE USE ONLY

The above applicant ☐ Does ☐ Does not have a substantiated recipient rights violation(s) according to BABH and ☐ Other CMHSP: _____ records.

By: _____ Date: _____

_____ Office of Recipient Rights