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

I, _____ authorize Bay Arenac Behavioral Health (BABH) and the
(print full name)
BABH Office of Recipient Rights 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.

I, _____ release BABH and BABH 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:

Stuart Wilson
Provider/Consumer

_____
Street Address

_____ 989-832-5404
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 records.

By: _____ Date: _____
BABH Office of Recipient Rights