AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION AND RELEASE OF LIABILITY
OFFICE OF RECIPIENT RIGHTS CHECK

I, _____, authorize Shiawassee County Community Mental Health Authority
(Print full name including middle name)
(SCCMHA) and the SCCMHA 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 SCCMHA and SCCMHA Office of Recipient Rights, its officers, its
(Print full name including middle name)
agents, and its employees from any and all liability claims, suits and actions of any nature brought against SCCMHA and the SCCMHA Office of Recipient Rights, its officers, its agents and its employees, etc. for disclosing information requested by me and I shall indemnify and hold harmless should any claim, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

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

_____ _____ _____
Applicant's Signature **Date** **Previous/Maiden Name Used (print)**

_____ _____ _____
Witness Signature **Date** **Title**

_____
Case Coordinator (If applicable)

INFORMATION TO BE SENT TO:

_____
Provider/Consumer

_____
Street Address

_____
City **State** **Zip Code** **FAX**

RIGHTS OFFICE USE ONLY

- ☐ The above applicant is eligible to work with SCCMHA recipients.
- ☐ The above applicant is not eligible to work with SCCMHA recipients.
- ☐ The above applicant does not have a substantiated recipient rights violation(s) according to SCCMHA records.
- ☐ The above applicant does have a substantiated recipient rights violation(s) according to SCCMHA records. Violations include:

_____

_____

_____

By:_____ Date_____
SCCMHA Office of Recipient Rights
SCCMHA ORR FAX: (989)723-0761

Revised: 10/26/16