St. Clair County Community Mental Health Authority

Employment Reference Release

AUTHORIZATION TO RELEASE INFORMATION AND COPY RECORDS

I authorize St. Clair County Community Mental Health Authority to release to:

_____

Employer

_____

Address

Information about my employment and job performance history while I am/was an employee of St. Clair County Community Mental Health Authority.

I specifically release from liability any current or former employer, its agents, representatives, employees, officers, or directors for giving such information to the above party.

INFORMATION TO BE RELEASED

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_____ _____

Signature Witness

_____ _____

Date Date