St. Clair County Community Mental Health Authority

OFFICE OF RECIPIENT RIGHTS

Authorization to Disclose Employee Information and Release of Liability

I, (print first and last name) _____, authorize St. Clair County Community Mental Health Authority's Office of Recipient Rights to disclose any reports/records regarding substantiated recipient rights violations to the party identified below for the purpose of verifying my eligibility for employment.

Further, I release St. Clair County Community Mental Health Authority, and its officers, agents, and employees from any and all claims, liability, and damages that may result from the release of said reports/records. In addition, I understand these reports/records may be provided to the Department of Licensing and Regulatory Affairs and Michigan Department of Health and Human Services, and I consent to the release of this information.

PREVIOUS PLACES OF EMPLOYMENT

1.) _____ Dates employed: _____ to _____

2.) _____ Dates employed: _____ to _____

3.) _____ Dates employed: _____ to _____

I have previously worked under the following name(s): _____

Applicant's Signature: _____Date: _____

Witness's Signature: _____Date: _____

RELEASE INFORMATION TO

Provider/Recipient Name: _____

OFFICE OF RECIPIENT RIGHTS – STAFF USE ONLY

According to the records of the St. Clair County Community Mental Health Authority's Office of Recipient Rights, the above named applicant ☐ DOES ☐ DOES NOT have a substantiated recipient rights complaint recorded with its office. If a substantiated complaint was discovered, it was recorded on (date) _____ and was issued for a violation in the following category: _____.

Records Reviewed by: _____Date: _____

Please submit forms via fax (810) 966-3393 Attn: Recipient Rights Office