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

I, _____, authorize Shiawassee Health and Wellness (SHW) and the SHW Office of Recipient
(Print full name including middle name)
Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipient rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, _____, release SHW and SHW Office of Recipient Rights, its officers, its agents, and its
(Print full name including middle name)
employees from any and all liability claims, suits and actions of any nature brought against SHW and the SHW 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 _____

Please check the appropriate box below

☐ I acknowledge that I have worked in the Mental Health field prior to my application for employment. I have worked in the following counties and give my permission for you to check with their county's Office of Recipient Rights:
_____

☐ I have not worked in the Mental Health field prior to my application for employment.

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

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

INFORMATION TO BE SENT TO:

_____
Provider/Consumer

_____
Street Address

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

RIGHTS OFFICE USE ONLY

The above applicant has the following recipient rights history:

Violation(s) of Abuse or Neglect: _____

Violation(s) of other recipient rights categories: _____

By: _____ Date_____
SHW Office of Recipient Rights Fax # (989) 723-0888

Revised: 02/02/21