Community Mental Health for Central Michigan

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

I, _____, authorize Community Mental Health for Central Michigan (CMHCM) and the
*(Print full name)*
CMHCM Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in possession of CMHCM regarding any violation of recipients' rights committed by me.

I, _____, release CMHCM and CMHCM Office of Recipient Rights, its officers, its agents,
*(Print full name)*
and its employees from any and all liability claims, suits and actions of any nature brought against CMHCM and the CMHCM Office of Recipient Rights, its officers, its agents and its employees, etc., for disclosing information requested by/about 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 Name Used (print)*

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

_____
*Case Coordinator*

**INFORMATION TO BE SENT TO:**

_____
Provider/Consumer

_____
Street Address

_____
City State Zip Code FAX #

**RIGHTS OFFICE USE ONLY**

☐ The above applicant does not have a substantiated recipient rights violation(s) according to CMHCM records.
☐ The above applicant does have a substantiated recipient rights violation(s) according to CMHCM records.
Violations include:

_____

_____

_____ _____
CMHCM Office of Recipient Rights Staff Date