St. Clair County Community Mental Health

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'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, 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'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

RR Form: #05-0250
Reviewed Date: 5/1/2024
Admin Procedure Ref: #06-001-0015