AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY

I, _____, authorize Genesee Health System (GHS) and the GHS
(print full name)
Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, _____, release GHS and the GHS Office of Recipient Rights, its
(print full name)
officers, its agents and its employees from any and all liability, claims, suits, and actions of any nature brought against GHS and the GHS Office of Recipient Rights, its officers, its agents and its employees etc. for disclosing the information requested by me and I shall indemnify and hold them harmless should any claims, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

1. _____ Dates employed: _____ to _____
2. _____ Dates employed: _____ to _____

_____ _____ _____
Applicant's Signature **Date** **Other names used**

_____ _____
Witness Signature **Date**

INFORMATION TO BE SENT TO:

_____
Provider/Consumer

_____
Street Address

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

Fax this form to (810) 257-3790 for processing

RIGHTS OFFICE USE ONLY

An individual with the above name does have a substantiated recipient rights violation(s) according to GHS records.

By: _____ Date: _____
GHS Office of Recipient Rights