AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY

I, _____, authorize Genesee Health System (GHS) and the GHS 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 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 Applicant's Date of Birth
(*_**must be verified by the provider**_)

_____
Other Names Used

*** The provider's witness must be an employee of the provider. By signing, the provider's witness certifies that they have personally verified the correct spelling of the applicant's name and the accuracy of the date of birth.**

_____ _____
Provider 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 **<u>does</u>** have a substantiated recipient rights violation(s) according to GHS records.

_____ _____
GHS Office of Recipient Rights Date