SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION AND RELEASE OF LIABILITY

Recipient Rights
Complaints
Appeals

PROVIDER INFORMATION:

Provider Name: Saginaw Psychological Services, Inc.	***Phone:989-799-2100***	***Fax: 989-799-2637***
Address: 2100 Hemmeter Rd		
City: Saginaw	***State: MI***	***Zip Code: 48603***

I, _____, authorize the Saginaw County Community Mental Health Authority
(PRINT FULL NAME)
to disclose to the PROVIDER listed above any and all information in your possession regarding any violations of recipients' rights committed by me. I recognize that any disclosures cannot include confidential client information protected by any Federal, State or common law.

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.

I, _____, release the Saginaw County Community Mental Health Authority
(PRINT FULL NAME)
and any other Community Mental Health Agencies I have listed on this form, its officers, agents, and employees from any and all liability, claims, suits and actions of any nature brought against them for disclosing the information requested by myself and the provider and I shall indemnify and hold them harmless should any such claims, suits or actions be filed against them.

_____ _____ _____
Applicant's Signature ***Date*** ***Applicant's Maiden Name (If Applicable)***

_____ _____ XXX-XX-_____
Witness Signature ***Date*** ***Applicant's Social Security Number (Last 4 Digits Only)***

_____
Applicant's Home Address: Street and Number City State Zip Code

RIGHTS OFFICE USE ONLY

A) The above applicant has the following Recipient Rights history:
Violation(s) of Abuse or Neglect according to:
SCCMHA ☐YES ☐NO**; Name of County**: _____☐YES ☐NO;
Name of County: _____☐YES ☐NO;
Name of County: _____☐YES ☐NO

B) The above applicant has the following Recipient Rights history:
Violation(s) of other Recipient Rights violations according to:
SCCMHA ☐YES ☐NO**; Name of County**: _____☐YES ☐NO;
Name of County: _____☐YES ☐NO;
Name of County: _____☐YES ☐NO

By: _____ Date: _____
SCCMHA Recipient Rights Advisor or Officer

Information from other counties was received from: County & ORR Staff: _____;
County & ORR Staff: _____; **County & ORR Staff**: _____;
Additional Forms may be used if there is a need to list more counties