AUTHORIZATION TO RELEASE

RECIPIENT RIGHTS INFORMATION

I,_____ authorize Community Mental Health Services Office of Recipient Rights to release to the following corporation or provider _____ any written reports or records regarding substantiated violations of Recipient Rights. I release Community Mental Health Services of Livingston County Office of Recipient Rights from any and all claims, liability and damages that may result from the release of these reports or records. I also understand that because of the nature of my job and licensing requirements, the information provided pursuant to this authorization may be provided to representatives of the Department of Consumer and Industry Services and/or other community health agencies. I hereby consent to the release of this information to these agencies.

_____

Applicant's Name (**please print**)

_____ _____

Applicant's Signature Date

_____

Other last name that may have been used (i.e. Maiden, Previous Marriage)

_____ _____

Witness Signature Date

Our search of the records show that the individual named above DOES____ DOES NOT _____ have written reports or record regarding substantiated violations of recipient rights.

_____ _____

Authorized Signature of Office of Recipient Rights Date

PROVIDER FAX: _____