Berrien Mental Health Authority - Riverwood Center
Office of Recipient Rights

AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION AND RELEASE OF LIABILITY OFFICE OF RECIPIENT RIGHTS CHECK

Please fill in all information

EMPLOYEE, POTENTIAL EMPLOYEE, OR CONTRACTED EMPLOYEE INFORMATION
FULL LEGAL NAME:
MAIDEN NAME OR PREVIOUS NAME(S) USED (IF ANY):

EMPLOYMENT HISTORY		
EMPLOYER	**BEGINNING DATE OF EMPLOYMENT**	**END DATE OF EMPLOYMENT**

By signing/typing below, I authorize the BMHA – Riverwood Center Office of Recipient Rights to disclose to the individual or agency listed below all information regarding any violation of recipient rights committed by me. I recognize that any such disclosure will not include confidential information protected by Federal, State, or common law.

I release BMHA Riverwood Center and BMHA – Riverwood Center 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 BMHA Riverwood Center and BMHA – Riverwood Center Office of Recipient Rights, its officers, its agents and its employees for disclosing information requested by me and I shall indemnify and hold harmless should any claim, suits or actions be filed against them.

_____ _____

Signature *Date*

Email this completed form to rights@riverwoodcenter.org