Authorization to Disclose Employee Information and Release of Liability
Office of Recipient Rights Check

Please type all information

Applicant Name:____

Previous Name(s) Used (if any):_________________________________

Previous Places of Employment:

1.______________________________ Dates employed __________ to __________

2.______________________________ Dates employed __________ to __________

3.______________________________ Dates employed __________ to __________

By signing/typing below, I authorize the Northern Lakes Community Mental Health Authority 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 Northern Lakes Community Mental Health Authority and the Northern Lakes Community Mental Health Authority 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 Northern Lakes Community Mental Health Authority and the Northern Lakes Community Mental Health Authority 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.

Authorization:________________________________ Date:________________

Email completed forms to: Recipient.Rights@NLCMH.ORG

Send Results to:

Name:________________________________

Email:____

Agency (if applicable):________________________

Phone Number:___________________________________

Results will be sent via email only*