Mid-State Health Network

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

I, _____, authorize Mid-State Health Network (MSHN) and the MSHN Office of
(Print full name)
Recipient Rights to disclose to the Provider/Consumer listed below any and all information in possession of MSHN regarding any violation of recipients' rights committed by me.

I, _____, release MSHN and MSHN Office of Recipient Rights, its officers, its agents,
(Print full name)
and its employees from any and all liability claims, suits and actions of any nature brought against MSHN and the MSHN Office of Recipient Rights, its officers, its agents and its employees, etc., for disclosing information requested by/about me and I shall indemnify and hold harmless should any claim, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT

1._____ Dates employed _____ to _____

2._____ Dates employed _____ to _____

3._____ Dates employed _____ to _____

_____ _____ _____
Applicant's Signature *Date* *Previous Name Used (print)*

_____ _____ _____
Witness Signature *Date* *Title*

_____
Case Coordinator

INFORMATION TO BE SENT TO:

_____ _____
Provider/Consumer *Fax Number*

_____
Street Address *City* *State* *ZIP Code*

RIGHTS OFFICE USE ONLY

☐ The above applicant does not have a substantiated recipient rights violation(s) according to MSHN records.
☐ The above applicant does have a substantiated recipient rights violation(s) according to MSHN records.

Violations include: _____

_____

_____

_____ _____
MSHN Office of Recipient Rights Staff Date