



AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION AND RELEASE OF LIABILITY

I, _____, authorize Oakland Community Health Network (OCHN) to disclose to the PROVIDER listed below 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.

I, _____, release Oakland Community Health Network, its officers, its agents and its employees from any and all liability, claims, suits and actions of any nature brought against Oakland Community Health Network, its officers, its agents and its employees for disclosing the information requested by me and I shall indemnify and hold them harmless should any such claims, suits or actions be filed against them.

APPLICANT SIGNATURE _____ DATE ____/____/____

APPLICANT'S PREVIOUS NAME/S OR MAIDEN NAME (IF APPLICABLE) _____

WITNESS SIGNATURE _____ DATE ____/____/____

APPLICANT'S LAST 4 DIGITS OF SS# _____

(Witness to ensure form is complete and legible before sending to process.)

DRIVER'S LICENSE #/STATE ID# _____

INFORMATION TO BE SENT TO:

DATE OF APPLICATION/HIRE _____

PROVIDER _____

STREET _____ CITY STATE ZIP CODE _____

PHONE CONTACT PERSON

Please fax this form back at _____ Attn: _____

Please mail this form back to the Provider address above, or email to this address _____

RIGHTS OFFICE USE ONLY

The above applicant *does _____ does not _____ have substantiated recipient rights violation(s) according to Oakland Community Health Network records.

*Violation Type(s) _____ Date(s) of Violation _____

By: _____ DATE: _____ Vicki L. Suder, Director of Rights and Advocacy