CONSENT TO RELEASE OF RECIPIENT RIGHTS INFORMATION

Send to: DWIHN-ORR
707 W. Milwaukee Street, 2nd floor
Detroit, MI 48202-2943
Phone: (888) 339-5595
Fax: (313) 833-7066 - Attn: DWIHN ORR

I, _____, hereby authorize Detroit Wayne Integrated Health Network (DWIHN), Office of Recipient Rights (DWIHN ORR) to release to:

Company/Name:
Address:
City, Zip
Phone:
Fax:

any and all written reports and records, including the outcome(s) of any investigation(s) of allegation(s) of abuse or neglect that the Recipient Rights Office has conducted involving me. By signing this Consent, I hereby release, waive and relinquish any and all claims against DWIHN, arising from the disclosure of information covered by this Consent to the third-party named above. I absolve DWIHN of any and all liability for the use of the information contained in any disclosed written reports and/or records. I fully understand and accept that the information contained in documents disclosed pursuant to this Consent may preclude my employment with third-party entities.

_____ _____
Name [please print] Maiden or Other name used [please print]

Last 4 digits of SSN: _____ Date of Birth: _____

Applicant Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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To Be Completed by Above Named Corporation:

I verify that the above named individual has been given a conditional offer of employment with the listed company and that the identifying information listed above matches the information provided in the application of employment completed by this individual, that the Recipient Rights information requested from DWIHN ORR pertains only to the time period specified below and that DWIHN ORR makes no representation as to whether the Recipient Rights information disclosed includes every Recipient Rights violation substantiated against the above named individual.

Signature of Executive Director/Designee_____ Date: _____

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To Be Completed by DWIHN ORR:

Upon review of our records for the period from _____ to _____, the following was discovered. For the above named individual:

☐ Was identified as violating a recipient's Michigan Mental Health Code protected right(s)

- Date(s) of report(s): _____
- Violation(s): _____

☐ Was not identified as violating a recipient's Michigan Mental Health Code protected right(s)

Signature for DWIHN ORR: _____ Date: _____