CONSENT TO RELEASE OF RECIPIENT RIGHTS INFORMATION

Send to: DWIHN-ORR
707 W. Milwaukee Street, 2nd floor
Detroit, MI 48202-2943
Phone: (313) 344-9099 ext. 3259
Fax: (313) 833-7066 - Attn: Linda Taylor

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

Name:
Address:
City, Zip
Phone:
Fax:

any and all written reports and records it has indicating I was involved in a **substantiated** Recipient Rights complaint. In signing this Consent, I waive any and all rights I may have, whether known or unknown, to commence any legal action against Detroit Wayne Integrated Health Network on the basis of any claim related to the disclosure of written reports and records covered by this Consent to the corporation named above. I absolve DWIHN of any and all liability for the use of the information contained in such written reports and records. I fully understand and accept that substantiated violations of a recipient's rights may preclude my employment with the above corporation.

_____ _____
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 and that the identifying information listed above matches the information provided by this individual. That Recipient Rights information provided by DWIHN ORR pertains only to the time period specified below. 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: _____

Revised September 5, 2019 by DWIHN ORR