

**Authorization to Disclose Employee Information and Release of Liability**

**CMH Agency:** \_\_\_\_\_

I, \_\_\_\_\_, authorize Alliance HR Alliance and CMH Office of Recipient Rights  
(Print Full Name)  
to disclose to the Provider/Consumer listed below any and all information in possession of CMH regarding any violation of recipients' rights committed by me.

I, \_\_\_\_\_, authorize Alliance HR Alliance and CMH, its Officers, its Agents, and  
(Print Full Name)  
its employees from and all liability claims, suites and actions of any nature brought against \_\_\_\_\_  
(Agency)  
and the CMH 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 place of Employment:

1. Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

2. Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

3. Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature & Title**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Case Manager**

**Please Return via Mail or Fax to:**  
**HR Alliance**  
**3290 W. Big Beaver Rd., Suite 510**  
**Troy, MI 48084**  
**FAX: 734-513-2706 or 844-830-9426**