Oakland Community Health Network

Developmental Disabilities • Mental Health • Substance Recovery

Office of Recipient Rights

AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION AND RELEASE OF LIABILITY

I, _____, authorize Oakland Community Health Network (OCHN) to disclose to
(PRINT FULL LEGAL NAME)
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
(PRINT FULL LEGAL NAME)
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.)

INFORMATION TO BE SENT TO: _____
APPLICANT'S DATE OF BIRTH
MONTH AND DAY ONLY

_____
PROVIDER

_____ _____
ADDRESS DRIVER'S LICENSE #/STATE ID#

_____ _____
CITY STATE ZIP CODE DATE OF APPLICATION/HIRE

_____
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.

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

ORR/Authorization to Disclose Revision 5-25-2021

FAX (947) 218-3834