Lenawee Community Mental Health Authority

AUTHORIZATION TO RELEASE
RECIPIENT RIGHTS INFORMATION

I, _____ authorize Lenawee Community Mental Health Services Office of Recipient Rights to release to the following corporation or provider _____ any written reports or records regarding substantiated violations of Recipient Rights. I release Community Mental Health Services of Lenawee County Office of Recipient Rights from any and all claims, liability and damages that may result from the release of these reports or records. I also understand that because of the nature of my job and licensing requirements, the information provided pursuant to this authorization may be provided to representatives of the Department of Consumer and Industry Services and/or other community health agencies. I hereby consent to the release of this information to these agencies.

_____
Applicant's Name (please print legibly)

_____ _____
Applicant's Signature Date

_____
Other last name(s) that may have been used (i.e. Maiden, Previous Marriage)

_____ _____
Witness Signature Date

Our search of the records show that the individual named above DOES ____ DOES NOT ____
Have written reports or record regarding substantiated violations of recipient rights.

_____ _____
Authorized signature of the Office of Recipient Rights Date

Provider Fax: _____

1040 South Winter Street, Suite 1022, Adrian, MI 49221
517.263.8905 · 1.800.664.5005 · Fax 517.263.7616 · www.lcmha.org