**I,**(**PRINT Full Name)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **authorize North Country Community Mental Health to disclose to the Provider listed below any information regarding violations of recipients’ rights substantiated against me.** I recognize that any disclosures will not include confidential client information protected by Federal and/or State law.

**I**, (**PRINT****Full Name**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ release North Country Community Mental Health,** its officers, its agents and its employees from any and all liability, claims suits, and actions of any nature brought against North Country Community Mental Health 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**  **Print** **Previous Name(s) Used** since 2018

**RETURN FORM TO** [Choose desired return contact below]:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # Fax # Email Address

**Recipient Rights Office Use Only**

* The above applicant **DOES NOT** have a substantiated recipient rights violation according to NCCMH records.
* The above applicant **DOES** have a substantiated recipient rights violation(s) according to NCCMH records. Violation(s) include:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NCCMH ORR Staff Date

**PROVIDER INSTRUCTIONS:**

This form may be used to complete a recipient rights “background check” as part of your employment process. **Please instruct the potential candidate to complete the top of the form.** **Names must be printed legibly to ensure the accuracy of the North Country CMH database search.** *Please note this is a search of NCCMH’s ORR database retroactively to FY ’18. Further, it does not include information from any other CMH agencies where the applicant may have worked previously.*

Complete the provider information section by writing your company name and the contact information where you would like the document returned to. Then send the form to the ORR at NCCMH for processing using email, fax, or mail**:**

**Email:** pmccleary@norcocmh.org

**Fax:** 231.439.8752

**Mail:** 1420 Plaza Drive, Petoskey, MI 49770, *Attention: ORR, Administrative Assistant II*

Once received, the ORR will immediately process the form and return it to you for your consideration. If you have any questions, or require more information, please contact the **Office of Recipient Rights at 800-281-0481.** Thank you!