



**Authorization to Disclose Employee Information and Release of Liability
Office of Recipient Rights Check**

Please type all information

Applicant Name: _____

Previous Name(s) Used (if any): _____

Previous Places of Employment:

- 1. _____ Dates employed _____ to _____
- 2. _____ Dates employed _____ to _____
- 3. _____ Dates employed _____ to _____

By signing/typing below, I authorize the Network180 Office of Recipient Rights to disclose to the individual or agency listed below all information regarding any violation of recipient rights committed by me. I recognize that any such disclosure will not include confidential information protected by Federal, State, or common law.

I release Network180 and the Network180 Office of Recipient Rights, its officers, its agents, and its employees from any and all liability claims, suits and actions of any nature brought against Network180 and the Network180 Office of Recipient Rights, its officers, its agents and its employees for disclosing information requested by me and I shall indemnify and hold harmless should any claim, suits or actions be filed against them.

Authorization: _____ Date: _____

Email completed forms to: orr@network180.org

Send Results to:

Name: _____

Email: _____

Agency (if applicable): _____

Phone Number: _____

****Results will be sent via email only****