



**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 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.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***Email completed forms to: [orr@network180.org](mailto:orr@network180.org)***

**Send Results to:**

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Agency (if applicable): \_\_\_\_\_

Phone Number: \_\_\_\_\_

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