RELEASE OF INFORMATION TO TRILLIUM HEALTH RESOURCES

Employee's Name ____

Position ____

I authorize____ (Name of EOR) to release information about me to TRILLIUM HEALTH RESOURCES so my qualifications can be reviewed to verify I have met minimum requirements to provide services in the NC Innovations Waiver. I understand as Lead Agency for the NC Innovations Waiver, TRILLIUM HEALTH RESOURCES will monitor services being provided to the individual for whom I am applying to become a service provider. In addition, my qualifications are subject to review by State and Federal Auditors as well as records I keep, including records of the time I work. TRILLIUM HEALTH RESOURCES and these Auditors are required by law to keep information they review confidential.

My Employer will maintain my records for at least five years. The results of my criminal background record check will not be disclosed to TRILLIUM HEALTH RESOURCES, state, or federal auditors.

A photocopy of this authorization form shall be as effective and binding as the original.

Applicant Signature ______________________________________ Date ________________________