San Mateo County Behavioral Health and Recovery Services
Change of Provider Request Form

You have the right to request a change of provider. Complete this form and give it to any staff member; they will forward it to the Unit Chief or Supervisor. The Unit Chief or Supervisor will review your request and respond to you within 2 weeks.

Your name (client): ______________________________________________________________

If youth, name of parent/guardian requesting change: ________________________________

I would like to change my:
Psychiatrist ☐  Case Manager ☐  Therapist ☐
Social Worker ☐  Nurse ☐  Clinic ☐  Program ☐

Name of provider/clinic: _____________________________________________________________

Your phone number(s) or contact information: __________________________________________

OPTIONAL - Reason for requesting a change of service provider: ______________________________

________________________________________________________________________________________

________________________________________________________________________________________

Client Signature: ____________________________________________ Date: ___________________

You also have the right to file a grievance. If you want to file a grievance, do not use this form, contact the Office of Consumer & Family Affairs at 1-800-388-5189.

http://smchealth.org/bhrs-documents  Policy 98-01
Attachment A: English Change of Provider Form, updated 10-22-19