



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: _____

FOR OFFICE USE ONLY	<u>Completed Form:</u> HS_BHRS_QM@smcgov.org or Fax 650-525-1762
Date Manager/Supervisor Received: _____	Client's MH#: _____
Decision: _____	
Date client informed of decision (<i>within 2 weeks of request</i>): _____	
Manager/Supervisor Printed Name: _____	Clinic: _____
Manager/Supervisor 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.