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 98-01 Attachment A