White Oak Psychiatric Services
4045 NE Lakewood Way, Suite 130, Lee's Summit, MO 64064
Phone: (816) 886-2184 Fax: (816) 886-2397

Patient Request for Change of Provider Form

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email Address: _____
- Address: _____

Current Provider Information:

- Provider Name: _____
- Department/Service: _____

Requested Provider Information:

- Provider Name (if known): _____
- Department/Service: _____

Reason for Request:_____

Additional Information: Please provide any additional details regarding your request to change providers:

Acknowledgment: By signing below, I acknowledge that my request will be reviewed by the clinic administration, and I may be contacted for additional information. I understand that while the clinic will make every effort to accommodate my request, a change in provider may depend on availability and other factors.

- Patient Signature: _____
- Date: _____

For Clinic Use Only:

- Date Request Received: _____
- Request Reviewed By: _____
- Outcome: [ ] Approved [ ] Denied [ ] Pending Further Review
- Comments/Notes: _____

Please return this form to: Whiteoak@whiteoakpsych.com