Consumer Transfer Notification and Consent Form

I _________________________________ request a transfer of case responsibility for
Consumer or Guardian

my services/supports **from** ____
Old/Previous Provider/Agency Name

to ____
New Provider/Agency Name

for ______________________________.
Consumer's Name

This does **not** prohibit me from transferring providers through Western Highlands Network in the future.

____ ________________
Consumer or Guardian Name (print & sign) Date

____ ________________
New Provider Clinician and title (print & sign) Date

____
New Provider/ Agency Name (please print)

This form is to be completed by consumer and/or guardian and given to the new provider at your first meeting with that provider. The provider will mail or fax the form to Access with the Screening Form and Access SAR. Ask your new provider for assistance. Please realize that a written Release of Information must be delivered to the old/previous provider in order to obtain past treatment/supports information. Please mail this form to:

Western Highlands Network - Access Unit **OR** Fax to Access Unit at 828-225-2782
356 Biltmore Avenue
Asheville, NC 28801