COMPLAINT FORM

Patient Full Name:

Date of Birth:
Address:

Complaint details: (Include dates, times, and names of practice personnel, if known)

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SIGNED.....Print name.....(Continue overleaf if necessary)

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____
TELEPHONE NUMBER: _____
ADDRESS: _____
_____

ENQUIRER / COMPLAINANT NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT THEN THE CONSENT OF THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW.

I fully consent to my Doctor releasing information to, and discussing my care and medical records with the person named above in relation to this complaint only, and I wish this person to complain on my behalf.

This authority is for an indefinite period / for a limited period only (delete as appropriate)

Where a limited period applies, this authority is valid until…….. (insert date)

Signed: …… (Patient only)

Date: ……..