PATIENT CONSENT FORM

|  |  |
| --- | --- |
| Name of patient you are complaining on behalf of: |  |
| Address: |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

I give consent for the disclosure of all relevant information from my medical record that is necessary to thoroughly investigate my complaint.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient signature: |  | Date: |  |
|  |  |  |  |
| I hereby authorise |  |  |
| to act as my complainant. |  |  |  |
| Patient relationship to complainant: |  |
|  |  |  |  |
| Complainant Name: (Block Capitals) |  |  |  |
|  |  |  |  |
| Complainant Signature: |  |  |  |
|  |  |  |  |
| Date: |  |  |  |