PATIENT CONSENT FORM

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

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: |  | | | | | | |  | | | |  | |