DRAYTON MEDICAL PRACTICE

PATIENT COMPLAINT FORM

Full Name:	
Date of Birth:	
Address:	

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

Signed:	
Date:	

Patient third-party consent

Patient's name:	
Date of Birth:	
Address:	

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. This consent is in relation to this complain 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:	