Tollgate Medical Centre

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)

WP 20/09/2024
Review 20/09/2025

Tollgate Medical Centre

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: ……..

WP 20/09/2024
Review 20/09/2025