ALTON STREET SURGERY

Alton Street, Ross-on-Wye, HR9 5AB

Third Party – Patient Complaint Form

The patient (The person who the complaint is regarding)

Name: _____

Date of birth: _____

Address: _____

Email address: _____

Telephone number: _____

Mobile number: _____

The representative (The person who represents the patient)

Name: _____

Date of birth: _____

Address: _____

Email address: _____

Telephone number: _____

Mobile number: _____

Relationship to patient: _____

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 or member of the Management team releasing information to, and discussing my care and medical records with the representative named above.

This authority is in relation to this complaint only

Signature: _____ Date: _____
(The Patient)