PATIENT COMPLAINT FORM – THIRD PARTY CONSENT

PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____

TELEPHONE NO: _____

ADDRESS: _____

_____

ENQUIRER/
COMPLAINANT NAME: _____

TELEPHONE NO: _____

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 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)

Date ……..

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