Olive Family Practice

COMPLAINT/COMPLIMENT FORM

Patient Full Name:

Date of Birth:
Address:

Complaint/Compliment details: (Include dates, times, and names of practice personnel, if known)

(Please continue overleaf if necessary)

SIGNED…….
Print name……

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

NAME OF PERSON
COMPLETING FORM: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

IF YOU COMPLETING THIS FORM ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR COMPLIMENT 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 form, and I wish this person to discuss this information 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: ……..