**PATIENT THIRD PARTY CONSENT**

Patients Name:

Patients Address:

**ENQUIRER/COMPLAINANT**

Name:

Telephone Number:

Email:

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 patients signed consent below:**

I fully consent to the practice releasing information to, and discussing my care and medical records with the person named above in relation to this complaint, 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 by Patient:

Print: Date:

**COMPLAINT FORM**

Patients Full Name:

Date of Birth:

Address:

Telephone Number:

Email

Preferred method of contact: Telephone Email Letter (please circle choice)

Date of Complaint:

Complaints details: (Include dates, times and names of practice personnel, if known)

Signed:

Print Name: