CRAWLEY DOWN HEALTH CENTRE

Version 1.1
Date published: November 2011
Reviewed but unchanged November 2014

COMPLAINT FORM

Patient Full Name: …… Date of Birth: ……..

Address: ……

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……..Telephone: ……..

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

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(Continue overleaf if necessary)

SIGNED……Print name……

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PATIENT THIRD-PARTY CONSENT

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

Patient Full Name: …… Date of Birth: ……..

Address: ……

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……..Telephone: ……..

Enquirer / complainant Name: …… Date of Birth: ……..

Address: ……

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……..Telephone: ……..

PATIENT TO READ AND SIGN

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: ……..