



COMPLAINT FORM

Patients full nameDate of Birth.....

Address.....
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Post Code..... Telephone Number.....

GMS Number.....

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

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..... (Continue Overleaf if necessary)

COMPLAINT FORM – PATIENT THIRD PARTY CONSENT

Patients full nameDate of Birth.....
 Address.....

 Post Code..... Telephone Number.....

Enquirer/ Complainants Full name
 Relationship to Patient
 Address
 Post Code.....
 Telephone Number

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 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: