



Grŵp Meddygol
argyle
Medical Group

Patient Consent Form

Someone raising a concern on your behalf

This form should be completed when a patient wants another person to raise a concern or complaint on their behalf and to communicate with the practice about the concern. Please complete all sections that apply. We will only use and share information that is relevant to dealing with the concern.

1. Patient details

Full name of patient:	
Address:	
Date of birth:	
Telephone:	
Email:	

2. Person authorised to raise the concern

Full name of representative:	
Relationship to patient:	
Address:	
Telephone:	
Email:	

3. What I am consenting to

I confirm that I give permission for the person named above to raise and discuss my concern with Argyle Medical Group on my behalf.

- I authorise the practice to communicate with this person about my concern, including providing them with information about the progress and outcome of the concern.
 - I consent to the practice accessing and using relevant information from my health record and other personal information where this is necessary to investigate and respond to my concern.
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- I understand that only information relevant and necessary to dealing with my concern will be disclosed, and that information will only be shared with people who need to know in order to handle the concern.
- I understand that this consent does not give the person named above general access to my medical records or authority to make decisions about my healthcare.
- I understand that I can withdraw or change this permission by contacting the practice. Any withdrawal will apply to future communication and disclosure, but information already used appropriately as part of the concern process will not necessarily be removed from the record.

4. Scope of the authorisation

Unless I state otherwise below, this authorisation applies to the concern currently being raised and to communications reasonably necessary to deal with that concern.

5. Patient declaration

I confirm that I have read and understood this form and that I am giving my permission for the person named above to act on my behalf in relation to my concern. I understand that the practice must protect my confidential information and will only disclose information relevant and necessary to dealing with the concern.

Signature of patient:

Date:

Name of patient (please print):

Signature of representative
(optional):

Date:

Practice use

Date received: _____ Received by: _____

Identity / authority of representative checked where appropriate: Yes / No