



**Office Use Only**

Date Complaint In ..... Clinician Involved.....

**PATIENT THIRD-PARTY CONSENT (if required)**

PATIENT'S NAME: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

ENQUIRER / COMPLAINANT NAME: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

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 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)

Print Name:.....(Patient)

Date: .....