Harolds Cross Medical Centre

COMPLAINT FORM

Patient Full Name:			
Date of Birth:			
Address:			
Complaint details: (Include dates,	, times, and na	mes of practice personnel, if known)	
SIGNED	Print		
Name	Date	(Continue overleaf if necessary	_/)

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: