HAROLDS CROSS MEDICAL COMPLAINT FORM

Patient Name _____

Date of Birth _____

Address _____

_____

Contact Number _____

Summary of the complaint, please give as much information as possible: What happened? Who was involved? When did it happen? Where did it happen? How did it happen? Why did it happen? What is your desired outcome? Any other information? *Continue overleaf if necessary…*

Patient Signature		Date	

Anonymous Complaints: In the interest of fairness we cannot investigate anonymous complaints.

Note: 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.

COMPLAINT FORM – PATIENT THIRD PARTY CONSENT

Patient Name	
Date of Birth	
Address	
Phone Number	

Complainant's Name	
Relationship to Patient	
Address	
Phone Number	

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 by Patient only : _____

Date: _____