

## PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM

<b>Patient Name</b>	
<b>Telephone No.</b>	
<b>Address</b>	

<b>Enquirer/Complainant Name</b>	
<b>Enquirer / Complainant's Relationship to patient</b>	
<b>Telephone No.</b>	
<b>Address</b>	

Please confirm your consent to one or more of the following;

- Yes please, I would like to receive communications by email**
- Yes please, I would like to receive communications by telephone**
- Yes please, I would like to receive communications by mobile phone including text message**
- Yes please, I would like to receive communications by post**

You can grant consent to all the purposes of use, some of them, or none.

Where a patient does not grant consent then the Practice will not be able to use their personal data, except in certain limited situations, e.g. where required to do so by law, or to protect the public from serious harm.

**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.

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 \_\_\_\_\_

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