



## COMPLAINT FORM

Patient Full Name: .....

Date of Birth: .....

Address: .....

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Complaint details: (Include dates, times, and names of practice personnel, if known)

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SIGNED .....

Print name ..... Date .....



**PATIENT THIRD-PARTY CONSENT**

PATIENT'S NAME:.....

TELEPHONE NUMBER:.....

ADDRESS:.....

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ENQUIRER / COMPLAINANT NAME:

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TELEPHONE NUMBER:.....

ADDRESS:.....

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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, 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 only)

Print name ..... Date .....