Version 2.0
Date published: May 2015
Reviewed and unchanged: Jan 2021

Rosemead Surgery

COMPLAINT FORM

Patient Full Name:……..

Date of Birth: ……..

Address: ……

……

……

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

……..

……..

……..

……..

……..

……..

……..

Please continue overleaf if necessary

SIGNED……

Print name: ……

Date: ……..

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PATIENT THIRD-PARTY CONSENT

Patient's name: ……..

Patient's telephone number: ……..……

Patient's address: .....

……..

……..

……..

Enquirer/ Complainant's 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 only)

Patient name (BLOCK CAPITALS) …….

Date: …….