OLMC

Old Leake Medical Centre

COMPLAINTS 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: ……………………………………………………………………….

THIRD-PARTY CONSENT FORM

Patient's Name: ………

Telephone Number: ………..

Address: ………

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Enquirer/Complainant Name: ………………………………………………………………………………………….

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)

Date: …………………………………………………………………

Version	Date	Version Created By:	Version Approved By:	Review Date
1	08/12/2016	Rachael Bell	Julie Lote	08/12/2017