PRIORY SURGERY

PATIENT COMPLAINT

THIRD-PARTY CONSENT FORM

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| PATIENT NAME: |  |
| TELEPHONE NUMBER: |  |
| ADDRESS: |  |
|  |
| ENQUIRER/COMPLAINANT 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, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_