HAWTHORN MEDICAL PRACTICE
COMPLAINT FORM

Patient Full Name:

Date of Birth:

Address:

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

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(Continue overleaf if necessary)

SIGNED…………………………………………………………

Print name………………………………………………….

PATIENT THIRD-PARTY CONSENT

PATIENT'S 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 declare that I have read and understood the complaint dated ……..……that has been made by the above named complainant regarding my care and that I would like the complaint to be investigated on my behalf.

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)

Date: ……..……..

Witnessed by ……