CLAREMONT MEDICAL CENTRE

PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM

PATIENT'S NAME: _____

PATIENT'S DOB: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

ENQUIRER / COMPLAINANT

NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

RELATIONSHIP TO PATIENT: _____

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF ANOTHER 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.

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)

Date……..