PATIENT COMPLAINT FORM

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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I consent to Meltham Road Surgery investigating my complaint dated ……………………. and I understand they may need to confer with other team members, other NHS or Social Care agencies involved in my care as well as the clinician's Indemnity Insurance Providers in the process of this review. I understand that, where possible, this will be done without disclosing my personal information but should this be necessary I consent to this disclosure for the purposes of a thorough investigation of my concerns.

Signature ……………………………………. Date / /

Print name ……………………………………….

Policy Updated 30/06/23
Policy Review Date 30/06/24
Policy Lead Shahda Chaudhry

MELTHAM ROAD SURGERY

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 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.

I consent to Meltham Road Surgery investigating my complaint dated above and I understand they may need to confer with other team members, other NHS or Social Care agencies involved in my care as well as the clinician's Indemnity Insurance Providers in the process of this review. I understand that, where possible, this will be done without disclosing my personal information but should this be necessary I consent to this disclosure for the purposes of a thorough investigation of my concerns.

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: …………………………………………..