



**PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM**

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

THIRD PARTY / 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 Pelham Medical Practice releasing information to, and discussing my care and medical records with the person named above.

Please tick one of the following boxes, as appropriate to, indicate how long you would like this authority to last and provide dates where requested:

- For an indefinite period
- For a limited period this authority is valid until ..... (insert date)
- For this complaint / issue only

Signed ..... (Patient)

Date.....

**Please return completed forms to the Practice Manager (Jason Bowler) 17, Pelham Road, Gravesend, Kent, DA11 0HN or if easier email to [jason.bowler@nhs.net](mailto:jason.bowler@nhs.net)**