PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

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.

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: _____