

# Brewood Medical Practice

## PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM

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.

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 .....