

Laurel House Surgery

Complaint Form

Patient's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Patient's D.O.B: \_\_\_\_\_

Complaint Details: (Please include dates, times, and names of practice personnel)

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(Continue overleaf if necessary)

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Laurel House Surgery

Patient Complaint – Third-Party Consent Form

Patient's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Complainant Name: \_\_\_\_\_

Address (if different): \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_