

**Patient Third-Party Enquiry / Complaint Consent Form**

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| **Patient Name:** |  |
| **Telephone No:** |  |
| **Address:** |  |
| **Enquirer / Complainant Name:** |  |
| **Telephone No.** |  |
| **Address:** |  |

If you are making an enquiry or 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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Insert name)

* Fully consent to my doctor releasing information to, and discussing my care and medical records with the person named above in relation to this enquiry / complaint, and I wish this person to enquire / complain on my behalf.
* This authority is for an indefinite period / for a limited period only (circle appropriate option).

Where a limited period applies, this authority is valid until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(please insert date)*

**Signed (Patient):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date** :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_