WALSH MEDICAL PRACTICE COMPLAINT FORM

Patient's Name: _____Date of Birth: _____

Address:

_____

Post Code: _____

Telephone Number_____ GMS Number: _____

Complaint details: **(Include dates, times and names of personnel, if known**)

Signed: _____ Date: _____

COMPLAINT FORM WITH PATIENT THIRD PARTY CONSENT

Enquirer/Complainant's Name: _____

Relationship to Patient: ……

Complainant's Address: ……
Post code ……Telephone number ……

If you are making a complaint for a patient, or if your complaint / query is about a patient's medical care, then we need consent from the patient. Please obtain the patient's signed consent below.

I 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.

***Signed…… (*Patient only) Date…….**