SOUTH GREEN SURGERY COMPLAINT FORM

Patient Full Name _____

Date of Birth _____

Address _____

_____

Telephone Number _____

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

Continue over leaf if required

SIGNED _____

Print name _____

DATE _____

SOUTH GREEN SURGERY COMPLAINT FORM

PATIENT THIRD-PARTY CONSENT

Patient Full Name _____

Date of Birth _____

Address _____

_____

_____

Telephone Number _____

Name of Person complaining on patient's behalf _____

Telephone Number _____

Address _____

_____

_____

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR 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. YOU SHOULD NOTE THE PRACTICE MAY CONTACT THE PATIENT DIRECTLY TO CONFIRM THIS INFORMATION

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.

Signature of patient _____

Date: _____