Patient Third Party Consent

Patient Full Name:	
Patient Date of Birth:	
Patient Address:	
Patient Post Code:	
Complainant Full Name:	
Complainant Address:	
Complainant Post Code:	
Complainant Contact Email Address:	
Complainant Contact Telephone Number:	

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 in relation to this complaint, and I wish this person to complain on my behalf.

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)

Patient signature:	
Print Name:	
Date:	

Please return this form via:

Email: complaints@pallmallmedical.co.uk

Post: Pall Mall Medical, 61 King Street, Manchester, M2 4PD

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