NEW MILTON HEALTH CENTRE PRACTICE

COMPLAINT FORM

If you have a complaint or concern about the service you have received from the doctors or any of the personnel working in this practice, please let us know. We operate a practice complaint procedure as part of an NHS complaints system, which meets national criteria.

Patient Full Name: **Date of Birth:**	**Address:**

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

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SIGNED……Print Name……

(Continue on separate sheet if necessary)

NEW MILTON HEALTH CENTRE PRACTICE

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

ENQUIRER / COMPLAINANT NAME:_____

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 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)

Signed ……(Patient only)

Date……