PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

ENQUIRER/COMPLAINANT
NAME: _____

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: ……