**Deansgrange Medical Centre**

**COMPLAINT FORM – PATIENT THIRD PARTY CONSENT**

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.

|  |  |
| --- | --- |
| Name of Patient  |  |
| Address  |  |
| Date of Birth |  |
|  |  |
| *Name of person making complaint*  |  |
| *Relationship to patient*  |  |

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.

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this signed form by post or email to info@deansgrangemedical.ie