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