**PATIENT COMPLAINT THIRD PARTY CONSENT FORM**

**Patient’s Name:**

Patient’s Address:

Patient’s Telephone Number:

**Enquirer/Complainant Name:**

Enquirer/Complainant Address:

Enquirer/Complainant 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):

Signed (Patient):

Date:

 Please return completed forms to:

The Practice Manager, The Castle Medical Group, Railway View Road, Clitheroe, BB7 2JG