**Kilmartin Medical**

**COMPLAINT FORM**

Patients full name .......................................................................................Date of Birth....................................

Address.................................................................................................................................................................

.......................................................................................................................Post Code.......................................

Telephone Number .......................................................................................GMS Number.................................

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

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(Continue Overleaf if necessary)

Signed................................................................................................................ Date..............................

**Kilmartin Medical**

**COMPLAINT FORM – PATIENT THIRD PARTY CONSENT**

Patients full name ..................................................................................................Date of Birth............................

Address....................................................................................................................................................................

................................................................................................................................ Post Code...............................

Telephone Number.................................................................................................................................................

Enquirer/ Complainants Full name .........................................................................................................

Relationship to Patient ............................................................................................................................

Address ...................................................................................................................................................

......................................................................................................................Post Code...........................

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 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: ……………………………………………………………………………………………………………………........