**PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM**

PATIENT'S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENQUIRER /

COMPLAINANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT, OR YOUR COMPLAINT/ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT, THEN THE CONSENT OF THAT 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.

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…………………………………………..