

# Phoenix Surgery

## COMPLAINT FORM

Patient Full Name:

Date of Birth:

Address:

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

SIGNED.....Print name.....  
(Continue overleaf if necessary)

**PATIENT THIRD-PARTY CONSENT**

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

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

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

ENQUIRER / COMPLAINANT NAME: \_\_\_\_\_

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

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

**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: .....