

PRACTICE COMPLAINT FORM

Patient Name	
Date of Birth	
Address	
Phone Number	

Summary of the complaint, please give as much information as possible:

What happened?
Who was involved?
When did it happen?
Where did it happen?
How did it happen?
Why did it happen?
What is your desired outcome?
Any other information?

Continue overleaf if necessary...

Signed		Date	
--------	--	------	--

Anonymous Complaints: In the interest of fairness we cannot investigate anonymous complaints.

Note: 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.

COMPLAINT FORM – PATIENT THIRD PARTY CONSENT

Patient Name	
Date of Birth	
Address	
Phone Number	

Complainant's Name	
Relationship to Patient	
Address	
Phone Number	

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: _____