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| **PROFESSOR A FUAT DR A MULLENHEIM DR M RANDALL****DR H RAZA DR G GEDDES** | **CARMEL MEDICAL PRACTICE****NUNNERY LANE DARLINGTON****DL3 8SQ****Telephone: (01325) 520794 Email:nencicb-tv.a83081-****eds@nhs.net** |

Patient Complaint Form – Third Party Consent Form

Patient Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone Number Enquirer / Complainant Details:

Full Name

Relationship to Patient Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_

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Telephone Number

If you are complaining on behalf of a patient or your complaint or enquiry involves the medical care of another 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.

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