BARRINGTON MEDICAL CENTRE

Altrincham Health & Wellbeing Centre 33 Market Street
Altrincham Cheshire WA14 1PF
Tel: 0161 928 9621 Email: reception.barrington@nhs.net

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____
TELEPHONE NUMBER: _____
ADDRESS: _____
_____

ENQUIRER / COMPLAINANT NAME: _____

RELATIONSHIP TO PATIENT: _____

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, 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:……..

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